Northern Inyo Healthcare District

Board Meetings

July 17, 2024 Regular Board of Directors Meeting

NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

July 17, 2024 at 5:30 p.m.

Northern Inyo Healthcare District invites you to join this meeting:

TO CONNECT VIA **ZOOM**: (*A link is also available on the NIHD Website*)
https://zoom.us/j/213497015?pwd=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09
Meeting ID: 213 497 015
Password: 608092

PHONE CONNECTION:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 213 497 015

The Board is again meeting in person at 2957 Birch Street Bishop, CA 93514. Members of the public will be allowed to attend in person or via zoom. Public comments can be made in person or via zoom.

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are **limited to three (3) minutes per speaker**, with a total time limit of thirty (30) minutes for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. New Business:
   A. 2023-2024 Employee Engagement Survey Report, Marjorie Routt – Human Resources Manager
   B. Chief Executive Officer Report *(Board will receive this report)*
      1. CEO Report

2. Associate CFO
3. Healthcare Financial Management Association (HFMA) Conference
4. CEO schedule update
5. Board Clerk

C. Chief Financial Officer Report
   1. Financial & Statistical Reports *(Board will consider the approval of these reports*)
   2. California – Cost of living increase
   3. Cerner
      a) Automation
      b) Unified Consumer Communications (U.C.C. Well)

D. Chief Medical Officer Report

E. Chief of Staff Report, Sierra Bourne MD:
   1. Policies (*Board will consider the approval of these Policies and Procedures*)
      a) Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program
      b) NIHD Antibiotic Stewardship Committee Charter
      c) NIHD Antibiotic Stewardship Program Plan
      d) Chaperone Use for Sensitive Exams
      e) Emergency Management Plan
      f) Mobile Intensive Care Nurse (MICN)
      g) DI – MRI Safety Plan
   2. Medical Staff Initial Appointments 2024-2025 *(Action item)*
      a) Talia Luc, PMHNP (*psychiatric mental health nurse practitioner*) – APP Staff
      b) Richard Thunder, MD (*orthopedic spine surgery*) – Courtesy Staff
      c) Jack Kornfeld, MD (*emergency medicine*) – Active Staff
      d) Bradley Clark, MD (*diagnostic radiology*) – Courtesy Staff
      e) Ann Marie Collier, MD (*neurology*) – Telemedicine Staff
   3. Initial Proxy Credentialing for Direct Radiology Group – 2024-2025 *(Action item)*

      As per the approved Physician Credentialing and Privileging Agreement, and as outlined by the Joint Commission and the Medicare Conditions of Participation, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon Direct Radiology's credentialing and privileging decisions.

      a) Sandeep N. Amesur, MD *(Diagnostic Radiology)*

b) John R. Anderson, DO *(Diagnostic Radiology)*
c) Asif Anwar, MD *(Diagnostic Radiology)*
d) David K. Bass, MD *(Diagnostic Radiology)*
e) Troy A. Belle, MD *(Diagnostic Radiology)*
f) Robert Berger, MD *(Diagnostic Radiology)*
g) Michael D. Berven, MD *(Diagnostic Radiology)*
h) John W. Boardmna, MD *(Diagnostic Radiology)*
i) Charles W. Westin, MD *(Diagnostic Radiology)*
j) Alexander R. Vogel, MD *(Diagnostic Radiology)*
k) James Brull, DO *(Diagnostic Radiology)*
l) Dennis M. Burton, MD *(Diagnostic Radiology)*
m) Sanford M. Smoot, MD *(Diagnostic Radiology)*
n) Courtney C. Carter, MD *(Diagnostic Radiology)*
o) Lillian W. Cavin, MD *(Diagnostic Radiology)*
p) Kenneth A Edgar, MD *(Diagnostic Radiology)*
q) Jeffrey W. Grossman, MD *(Diagnostic Radiology)*
r) Mark L. Harshany, MD *(Diagnostic Radiology)*
s) James C. Haug, DO *(Diagnostic Radiology)*
t) Miriam B. Hulkower, MD *(Diagnostic Radiology)*
u) Ellen D. Johnson, MD *(Diagnostic Radiology)*
v) Benjamin R. Park, DO *(Diagnostic Radiology)*
w) William E. Phillips, MD *(Diagnostic Radiology)*
x) Teppe Popovich, MD *(Diagnostic Radiology)*
y) William T. Randazzo, MD *(Diagnostic Radiology)*
z) Avez A. Rizvi, MD *(Diagnostic Radiology)*
aa) Faranak Sadri Tafazoli, MD *(Diagnostic Radiology)*
bb) Dishant G. Shah, MD *(Diagnostic Radiology)*
cc) Shree J. Shah, MD *(Diagnostic Radiology)*
dd) Masood A. Siddiqui, DO *(Diagnostic Radiology)*

4. Change in Staff Category *(Action item)*
   a) Gregory Gaskin, MD *(emergency medicine)* – change from Active Staff to Courtesy Staff

5. Medical Staff Governance Structure for Fiscal Year 2024-2025 *(information item)*
6. Medical Executive Committee Report *(Board will receive this report)*

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4. **Consent Agenda -** *All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.*
   A. Approval of minutes of the June 19, 2024 Regular Board Meeting
   B. Approval of minutes of the July 3, 2024 Special Board Meeting
   C. CEO Credit Card Statements
   D. Approval of Policies and Procedures
      1. Laboratory Biosafety Plan
      2. Environmental Tours

   E. General Information from Board Members (*Board will provide this information*)
   F. Adjournment

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact administration at (760) 873-2838 at least 48 hours prior to the meeting.

NORTHERN INYO HEALTHCARE DISTRICT
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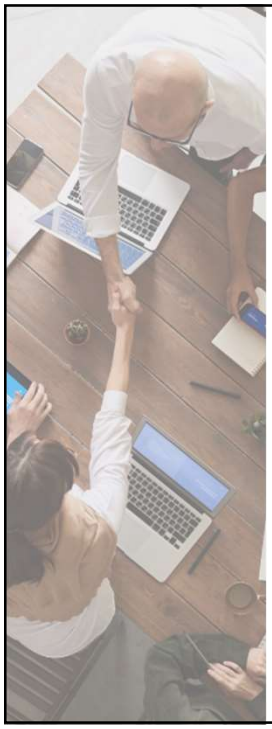
Satisfaction & Engagement 2023 – 2024 Executive Presentation



People element



High-Level Overview

Process Overview

- Data collected Feb – March 2024
- Data was collected via Email
- Survey confidentiality is maintained by only reporting data in aggregate with a confidentiality threshold of 3 responses

High-Level Results

- Participation: 57% (276/486)
  - *8% increase compared to 2022*
- Overall % Favorability: 71%
  - *11% increase compared to 2022*
- Engagement Level: 58%
  - *10% increase compared to 2022*

People element

Survey Categories

BY % FAVORABILITY

Category	Mean	% Favorable	Comparison to Company	2022 Comparison
Overall Indicators	4.09	77	+6	+12
Job Satisfaction	4.07	77	+6	+3
Culture	3.98	73	+2	+11
Manager	4.00	72	+1	+4
Workforce Well-being	3.79	67	-4	+11
Directors	3.78	67	-4	+9
Inclusivity	3.72	66	-5	+9
Executive Leadership	3.61	62	-9	+29

Mean
The category average score on a scale of 1-5

% Favorable
The % of favorable responses (4's & 5's)

Comparison to Company
Difference in category & overall % favorability

2022 Comparison
Difference in % favorability compared to 2022

People element

Highest Rated Items

BY % FAVORABILITY

Highest Rated Items	Category	Mean	% Fav	Comparison to Company	2022 Comparison
I plan to be here at least 1 year from now.	Overall Indicators	4.41	87	+16	+8
My work is an important part of my life.	Job Satisfaction	4.32	87	+16	+3
I am highly engaged in my work.	Job Satisfaction	4.30	87	+16	+6
My work gives me a sense of personal accomplishment.	Job Satisfaction	4.25	85	+14	+2
I am not afraid for my physical safety while working.	Workforce Well-Being	4.26	84	+13	+1
I am motivated to go beyond what is normally expected of me to help NIHD be successful.	Culture	4.18	80	+9	+7
I feel proud to work for NIHD.	Culture	4.12	80	+9	+13
I am satisfied with NIHD as a place to work.	Overall Indicators	4.08	79	+8	+13
I would recommend NIHD as a good place to work in the community.	Overall Indicators	4.07	77	+6	+15
I am satisfied with the health and safety practices of NIHD.	Workforce Well-Being	3.96	77	+6	+11

People element

Lowest Rated Items

BY % FAVORABILITY

Lowest Rated Items	Category	Mean	% Fav	Comparison to Company	2022 Comparison
Executive leadership communicates a clear vision for the organization's future.	Executive Leadership	3.68	64	-7	+33
Establishes a climate that is open to differing ideas and opinions	Inclusivity	3.61	63	-8	+11
Ensures all workforce members have an opportunity to participate in discussions	Inclusivity	3.70	62	-9	+8
I am confident in NIHD's ability to adapt as needed.	Workforce Well-Being	3.70	62	-9	+20
Executive leadership's actions show they value NIHD workforce.	Executive Leadership	3.60	62	-9	+25
I feel valued as a member of the NIHD workforce.	Culture	3.69	61	-10	+13
I have the resources and support I need to effectively manage my stress.	Workforce Well-Being	3.61	61	-10	+8
Leadership listens to and cares about workforce concerns.	Workforce Well-Being	3.65	59	-12	+13
I am satisfied with NIHD's communication to workforce members.	Workforce Well-Being	3.58	59	-12	+13
Executive leadership is effective in resolving key organizational issues.	Executive Leadership	3.55	58	-13	+28

People element

Most Increased/Decreased

2022/2024 COMPARISON

MOST INCREASED	Category	% Fav	2022 Comparison
Executive leadership communicates a clear vision for the organization's future.	Executive Leadership	64	+33
Executive leadership is effective in resolving key organizational issues.	Executive Leadership	58	+28
Executive leadership's actions show they value NIHD workforce.	Executive Leadership	62	+25
I am confident in NIHD's ability to adapt as needed.	Workforce Well-being	62	+20
I would recommend NIHD as a good place to work in the community.	Overall Indicators	77	+15
I don't consider looking for a new job elsewhere.	Overall Indicators	74	+15
I feel proud to work for NIHD.	Culture	80	+13
I am satisfied with NIHD as a place to work.	Overall Indicators	79	+13
I feel valued as a member of the NIHD workforce.	Culture	61	+13
Leadership listens to and cares about workforce concerns.	Workforce Well-being	59	+13
I am satisfied with NIHD's communication to workforce members.	Workforce Well-being	59	+13
I find my values and the organization's values are very similar.	Overall Indicators	74	+12
Encourages others to share their ideas and opinions	Inclusivity	69	+12
My director communicates a clear vision for the department's future.	Directors	66	+12

People element

Results By Tenure

BY % FAVORABILITY

View By Category	Overall	Less than 3 months	3 months - less than 6 months	6 months - less than 1 year	1 year - less than 3 years	3 years - less than 5 years	5 years - less than 10 years	10 years - less than 15 years	15 years or more
# of Respondents (N)	241	9	5	8	56	37	68	25	33
Overall % Favorable	71	79	72	81	76	68	66	66	76
Culture	73	85	76	70	78	67	67	73	78
Directors	67	67	73	96	68	68	56	68	79
Executive Leadership	60	77	40	62	65	58	53	57	67
Inclusivity	66	78	69	78	71	65	60	59	69
Job Satisfaction	78	76	67	81	83	76	77	72	82
Manager	72	70	60	88	85	73	67	63	68
Overall Indicators	78	81	83	90	83	74	74	74	83
Workforce Well-being	66	83	86	83	72	61	59	55	74

People element

Results By Generation

BY % FAVORABILITY

View By Category	Overall	Gen Z (1997-2012)	Millennials (1980-1996)	Gen X (1965-1979)	Baby Boomers (1946-1964)
# of Respondents (N)	241	19	115	72	35
Overall % Favorable	71	73	66	77	75
Culture	73	78	65	80	79
Directors	67	73	64	68	70
Executive Leadership	60	63	53	66	70
Inclusivity	66	68	60	76	62
Job Satisfaction	78	80	72	86	83
Manager	72	67	72	75	71
Overall Indicators	78	79	74	82	84
Workforce Well-being	66	65	63	71	70

People element

Enjoy Most?

What do you enjoy most about working at this organization?

People/Patients/Coworkers
- We get to have some good coworkers and you're able to express yourself with them…
- Serving patients, working with compassionate and dedicated co-workers.
- The people that I work with, the gratitude of the patients that I serve.
- I love my coworkers and taking care of people in my community.

Work Life/Schedule
- Work/life balance…being in close proximity to the school & the ability to show up for my kids…is of the highest priority to me.
- I enjoy the work life balance and the support from the management team in this regard.
- It provides the ability to have a better balance in life.
- Healthy work/life balance.

Type of Work
- It supports the community's health goals we're a small town & it's important…we provide a high standard of care to everyone.
- Being able to go above & beyond for my community…getting people…the right care & resolving…health concerns.
- Being able to use my skillsets to help my coworkers in doing their jobs & thereby…helping our patients & clients.
- Enjoy helping people in the community to achieve better health…

See comment report for full details

People element

Most Improve?

What could most improve this organization as a place to work?

Communication
- Communication within departments…one day we're doing one workflow & then the next we're expected to do something else…
- Transparency is always an area to improve upon. I feel that communication has improved…but…this should always be a goal.
- Better communication and workflow, standard operating procedure.
- More communication from manager to employee.

Leadership/Management
- When things are brought to anyone who is higher up i.e., managers/directors…it would be nice to see some follow through…
- Leadership should talk to the people actually doing the work & not the directors or…managers…
- Avoid toxic supervisors that make you feel intimidated.
- Management listening to their employees.

Resources & Support
- Involve the frontline workers with decisions that are made that involves our patients such as equipment choices etc.
- More support staffing & better provider-to-staff ratio to meet productivity goals.
- 24-hour security guards to assist with patients and visitors and staff.
- Continued support of the staff.

See comment report for full details

People element

Employee Engagement

People element

Employee Engagement

The emotional connection an employee feels toward the organization and its goals

Engagement Index

Connection

- My work gives me a sense of accomplishment
- I'm proud to work for my organization

Commitment

- I plan to be with the company at least 1 year from now
- I don't consider looking for a job elsewhere

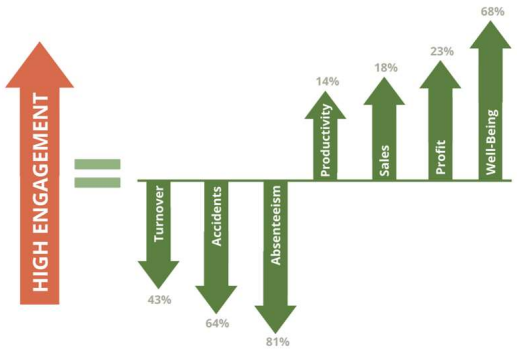
Advocacy

- I would recommend the organization as a good place to work

Effort

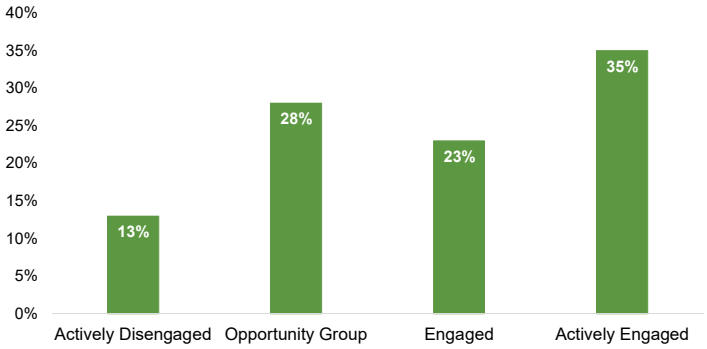
- I am motivated to go beyond what is normally expected of me to help the organization be successful

Engagement Outcomes



People element

Engagement Level



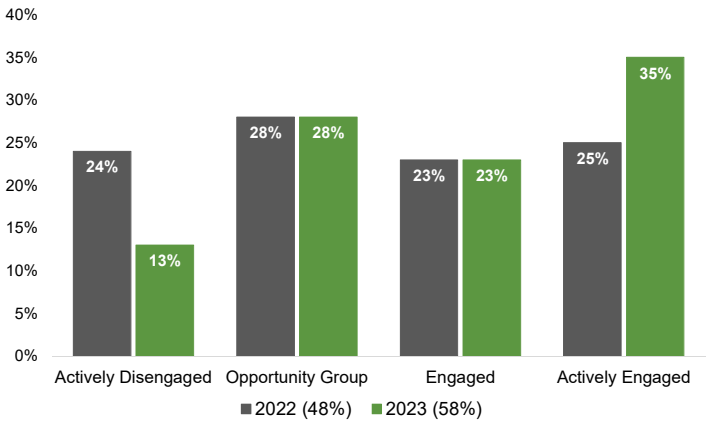
Key Takeaways

- The majority of the employee population is engaged based on People Element's engagement measurement.
- This is slightly above average engagement when compared to People Element's global benchmark (2023 – 56%)

People element

Engagement Level - Historical

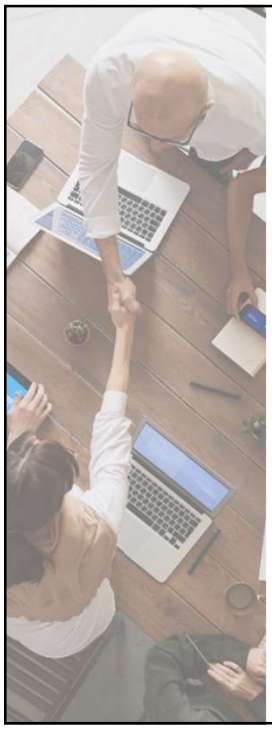
2022/2023 COMPARISON



Key Takeaways

- Engagement Level has increased 10% when compared to 2022.

People element



Key Drivers of Engagement

CULTURE & ENVIRONMENT
- I feel valued as a member of the NIHD workforce.
- Establishes a climate that is open to differing ideas and opinions.

LEADERSHIP
- Executive leadership's actions show they value NIHD workforce.
- Leadership listens to and cares about workforce concerns.
- Executive leadership communicates a clear vision for the organization's future.

WORK/LIFE BALANCE
- The organization supports me in maintaining a work/life balance.

People element

Recommended Areas of Focus

CULTURE & ENVIRONMENT
- I feel valued as a member of the NIHD workforce.
- Establishes a climate that is open to differing ideas and opinions.

LEADERSHIP
- Executive leadership's actions show they value NIHD workforce.
- Leadership listens to and cares about workforce concerns.
- Executive leadership communicates a clear vision for the organization's future.

WORK/LIFE BALANCE
- The organization supports me in maintaining a work/life balance.

Key Takeaways

- The Key Drivers of Engagement are not the lowest scoring items. Instead, they are the lowest scoring items with the highest impact on engagement.
- Improving scores around these items will give the organization the best chance at improving and/or maintaining engagement.
- Employees were asked if they believe changes will be made based on the feedback they provided.

People element

Approach to Action Planning

Org-Wide Action:

To ensure org-wide action is taken and not bottlenecked within leadership or HR, it can be helpful to create an Engagement Committee. This helps to create employee ownership, encourage diverse and innovative solutions, and serve as a development opportunity for committee members.

- *Appoint an Executive Sponsor:* This is typically a member of leadership or HR. This role will set expectations, ask difficult questions, hold the committee accountable, and report their recommendations back to leadership for approval. Ideally, the executive sponsor is familiar with the People Element Platform and reporting.
- *Build a Team:* Recruit a cross-functional team (6-12 people) from diverse roles within your organization. Typically, the team is recruited through a volunteer process but can be selected by leadership if needed. The team will be responsible for pinpointing focus areas and providing the executive sponsor with action items to present to leadership. They're also responsible for managing the execution of the approved action plans.
- *Cascade Data:* The executive sponsor will share org-wide results with the engagement committee in as much detail as needed to action plan. This might include providing them with access to the People Element Platform or sharing exported reports.
- *Accountability:* It's important to record your action plans and track their progress for an added layer of accountability. The People Element Platform makes it easy to record your plans using our action planning tool.

People element

Approach to Action Planning – Cont.

Key Demographic Action:

With action planning already occurring at the org-wide level, some action will be targeted by a key demographic such as manager or department. This depends on what demographics you have available and how much data you have per demographic . However, finding the right demographic will give mid/front line leaders a chance to make improvements specific to their teams.

- *Key Demographic:* It's important to find the demographic that works best for your organization. While it may sound great for every manager to build an action plan, there may not be enough data by manager, or depending on the number of managers, you may not have the resources to manage the process. Other common demographics that work are department, job family, or location.
- *Cascade Data:* Provide demographic specific data to the people responsible for acting. For example, if you're taking action by department, provide each department head with access to their data (survey & data level access).
- *Data Education:* Ensure the people acting have a solid understanding of the platform and their data. The People Element Knowledge Base is filled with helpful resources, but having someone familiar with reporting review their results with them and help them prioritize opportunities can also be helpful. People Element also has a Manager Action Guide available, intended to help managers and team leaders create plans.
- *Accountability:* It's important to record your action plans and track their progress for an added layer of accountability. The People Element Platform makes it easy to record your plans using our action planning tool.

People element

Recommendations

Senior Leadership

- **Post Survey Communication**: Have Senior Leadership own post survey communication. Thank employees for their feedback, reiterate confidentiality and the reason the survey was administered, share successes and opportunities (that you plan to act on) and keep employees updated on action planning progress. This will show employees their feedback was heard and taken seriously.
- **Communication Plan**: Assess current avenues of communication from the Senior Leadership Team to employees. Ensure your leadership communication strategy includes the following 5 points:
  1. Communications should always be appropriately transparent, empathic & specific.
  2. Listen – create opportunities for employees to provide input & ask questions to leadership.
  3. Use as many delivery mediums as possible as people absorb information in different ways (company/dept. meeting, video, recorded messages, email, etc.).
  4. Establish an appropriate frequency of communications and be consistent.
  5. Under the current circumstances, we recommend the following topics be covered:
     - Clear vision in 2024 and the next 3 to 5 years.
     - How employees can help the department reach its goals – help them connect themselves to your vision.
     - Provide appropriate encouragement, hope, and gratitude for their efforts.
- **Continuous Listening Initiative**: The Leadership Team needs to ensure employees know that this survey is a way to hear their ideas and suggestions and that it will be done on an annual basis. Communicate that this is important to the organization because they are valued as employees and their feedback will play a critical role in making improvements.

NORTHERN INYO HEALTHCARE DISTRICT
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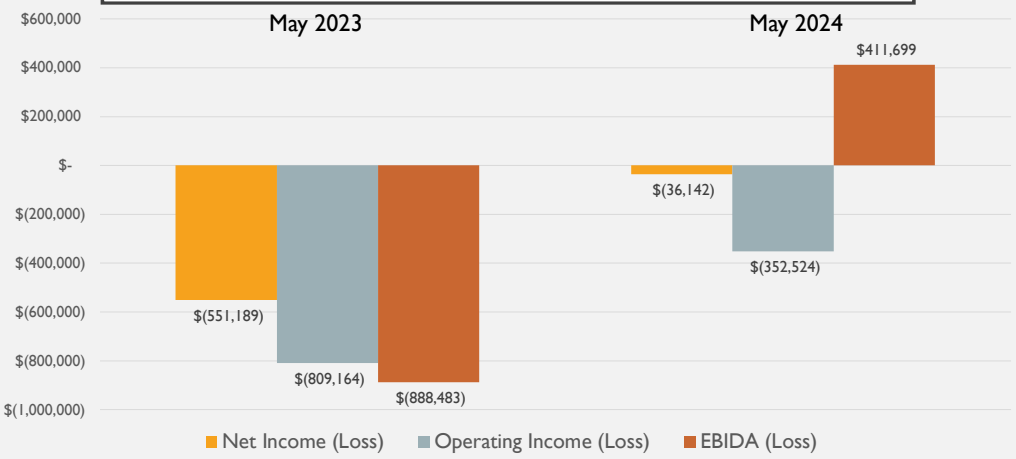
NIHD FINANCIAL UPDATE

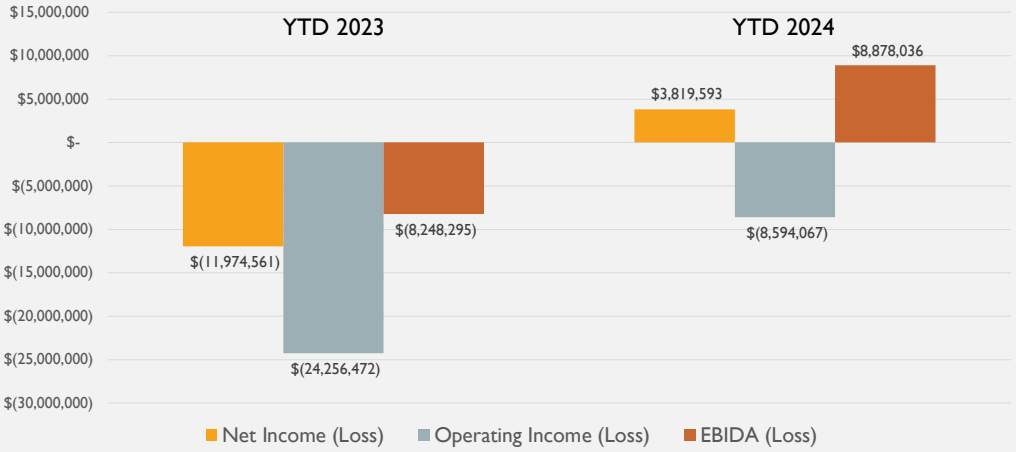
May 2024

INCOME

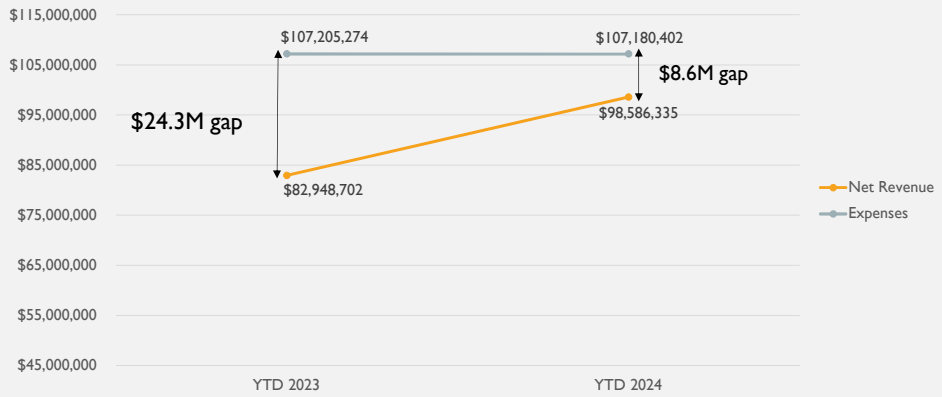
MAY 2024 FINANCIAL PERFORMANCE



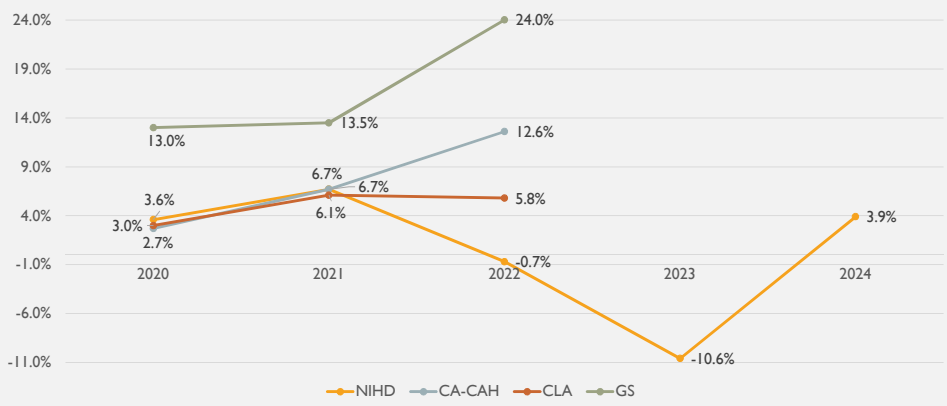
FYE 2024 FINANCIAL PERFORMANCE



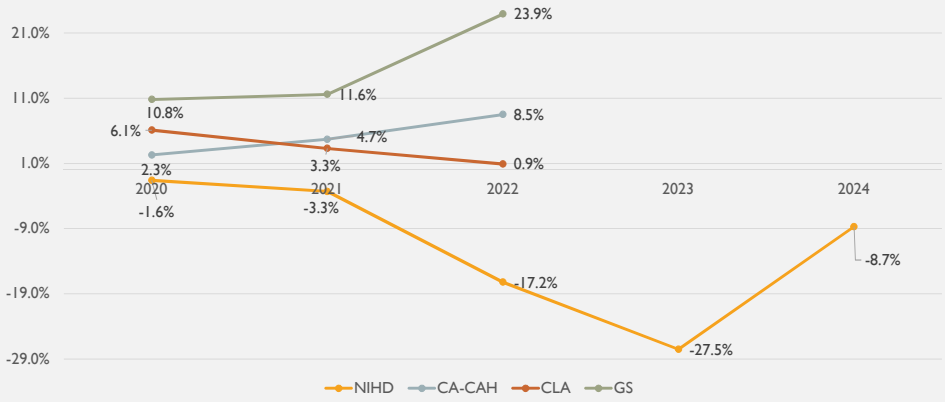
YTD OPERATING INCOME (LOSS) PERFORMANCE



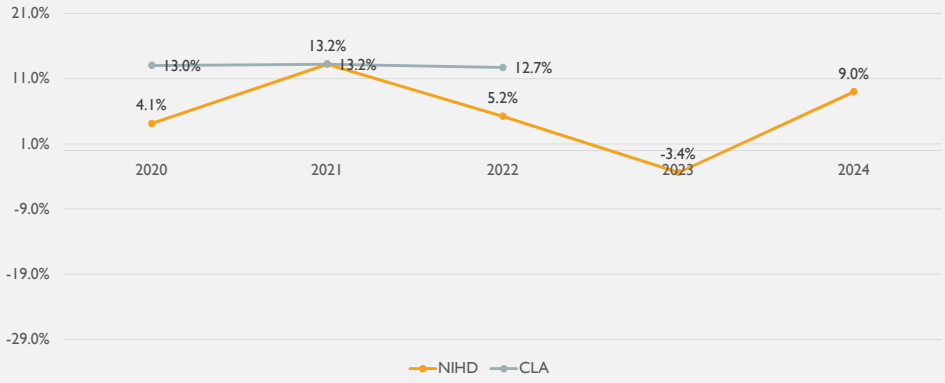
NET PROFIT MARGIN



OPERATING MARGIN

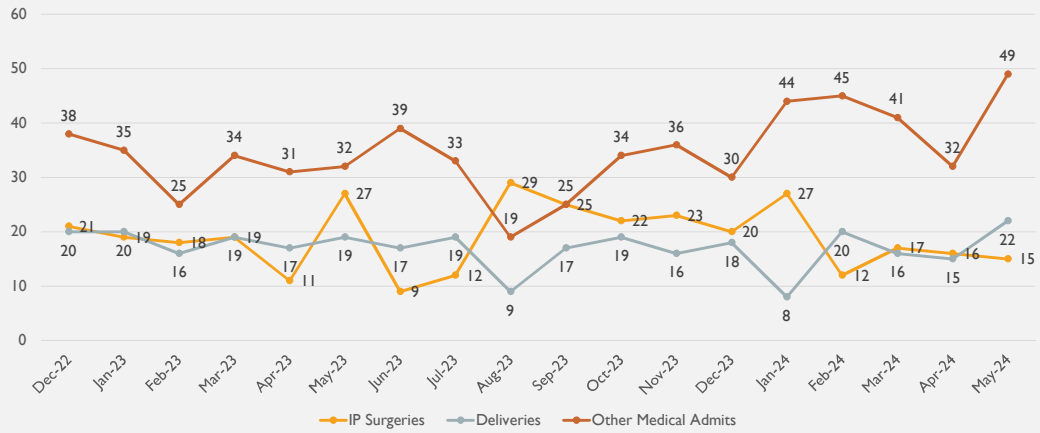


EBIDA MARGIN

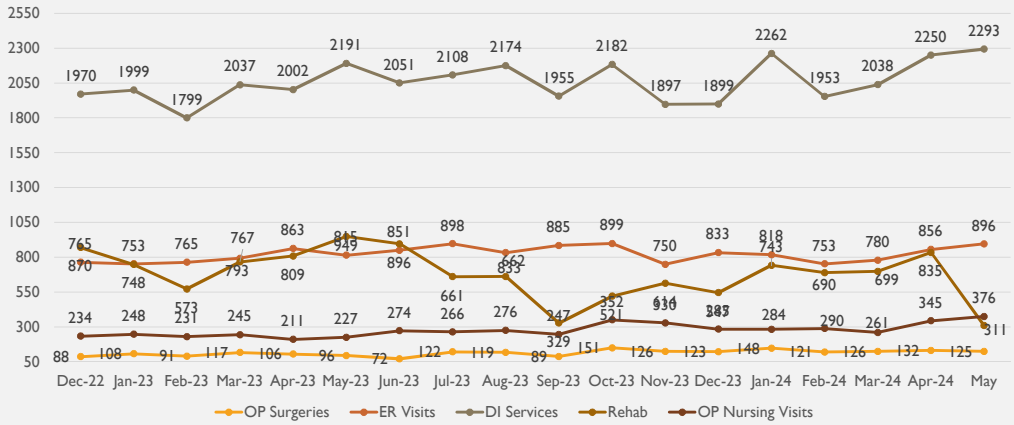


VOLUMES

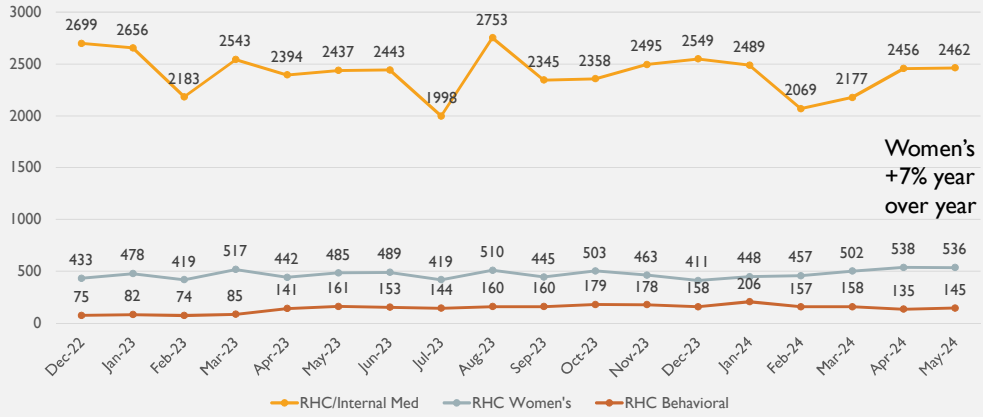
INPATIENT VOLUME PERFORMANCE



OUTPATIENT VOLUME PERFORMANCE

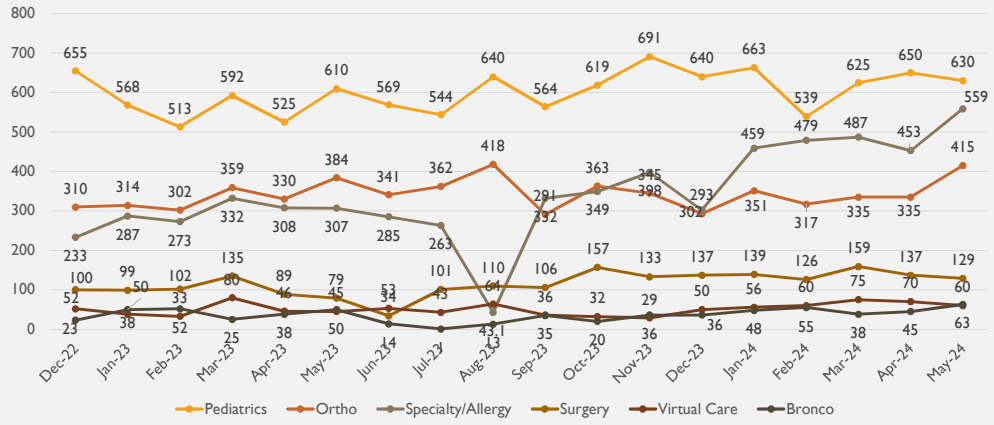


RHC VOLUME PERFORMANCE



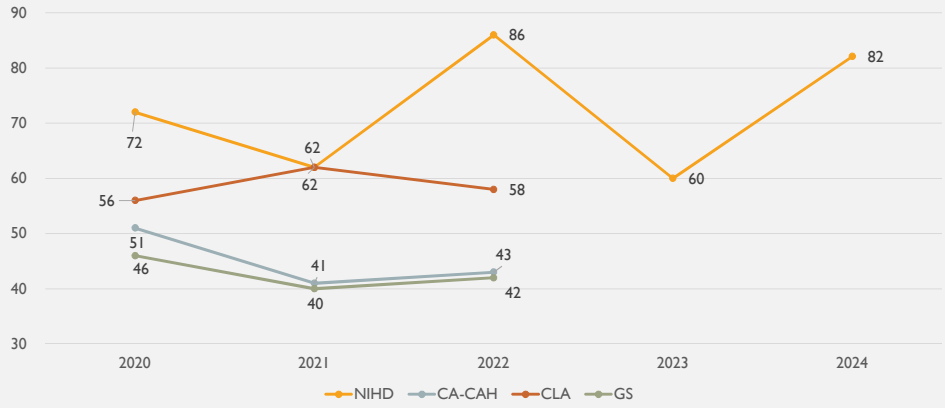
Women's +7% year over year

CLINIC VOLUME PERFORMANCE

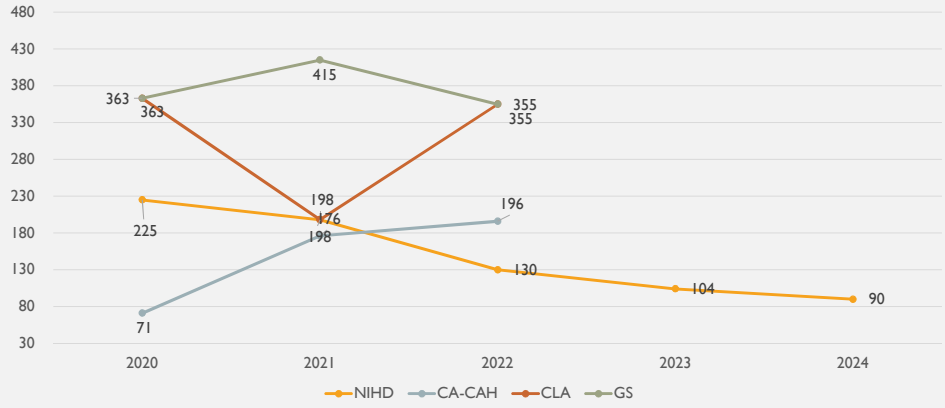


KEY PERFORMANCE INDICATORS

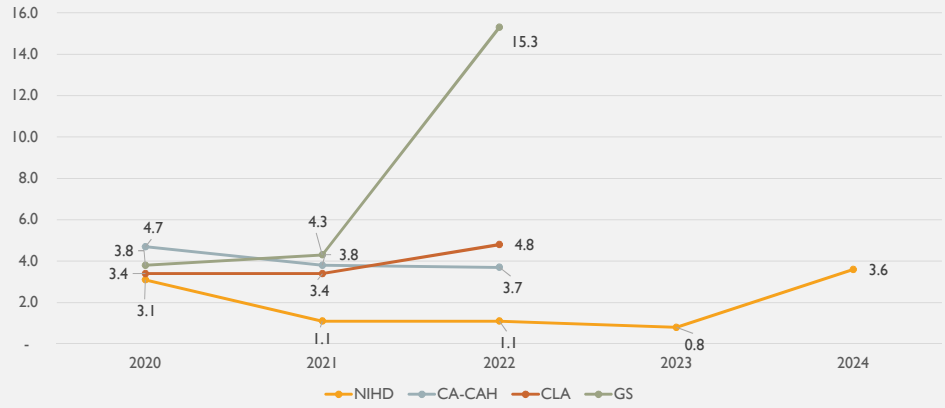
AR DAYS



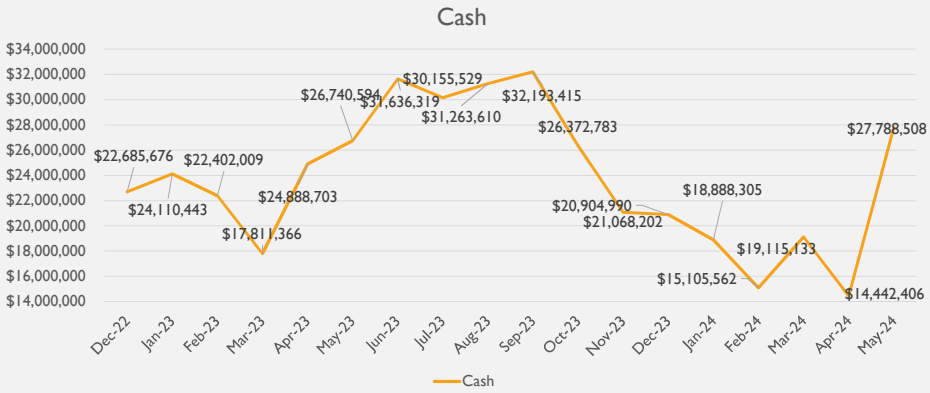
DAYS CASH ON HAND



DEBT SERVICE COVERAGE RATIO



UNRESTRICTED FUNDS



WAGE COSTS

	YTD 2023	YTD 2024	% Change
Total Paid FTEs	441	381	-13%
Salaries, Wages, Benefits (SWB) Expense	$54.7M	$54.6M	0%
SWB % of total expenses	51%	51%	0%
Employed Average Hourly Rate	$42.74	$52.48	23%
Benefits % of Wages	70%	54%	-14%

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2024

	2/29/2024	2/28/2023	3/31/2024	3/31/2023	4/30/2024	4/31/2023	5/31/2024	5/31/2023	2024 YTD	2023 YTD	PYM Change	PYTD Change
Gross Patient Service Revenue												
Inpatient Patient Revenue	3,063,000	2,545,535	3,740,981	3,633,689	3,215,615	2,295,049	3,646,287	3,261,629	38,554,203	34,660,937	384,658	3,893,266
Outpatient Revenue	12,719,309	11,030,636	11,921,652	12,610,463	15,650,478	12,236,228	14,890,447	13,355,732	152,183,966	133,144,537	1,534,715	19,039,429
Clinic Revenue	1,500,716	1,266,634	1,601,821	1,550,929	1,763,094	1,390,394	1,822,994	1,526,050	17,723,375	15,509,478	296,944	2,213,897
Gross Patient Service Revenue	17,283,024	14,842,805	17,264,454	17,795,080	20,629,186	15,921,672	20,359,728	18,143,411	208,461,544	183,314,952	2,216,317	25,146,593
Deductions from Revenue												
Contractual Adjustments	(9,066,535)	(6,829,397)	(15,144,877)	(9,900,790)	(10,525,952)	(8,452,990)	(9,761,982)	(8,271,575)	(103,077,386)	(86,463,310)	(1,490,407)	(16,614,077)
Bad Debt	(285,977)	(1,387,069)	4,239,262	525,913	131,776	(240,320)	(538,525)	(1,264,180)	(1,663,671)	(8,885,782)	725,655	7,222,111
A/R Writeoffs	(567,860)	(234,813)	(706,178)	(721,088)	(285,526)	(450,123)	(410,472)	(245,437)	(5,141,184)	(4,874,515)	(165,035)	(266,669)
Other Deductions from Revenue	-	-	-	38	53	(637,163)	-	-	53	(187,687)	-	187,741
Deductions from Revenue	(9,920,372)	(8,451,279)	(11,611,793)	(10,095,928)	(10,679,648)	(9,780,597)	(10,710,978)	(9,781,192)	(109,882,187)	(100,411,293)	(929,786)	(9,470,894)
Other Patient Revenue												
Incentive Income	-	-	-	-	-	-	-	-	-	-	-	-
Other Oper Rev - Rehab Thera Serv	862	1,660	-	5,396	-	929	3,163	696	6,979	45,044	2,467	(38,065)
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	862	1,660	-	5,396	-	929	3,163	696	6,979	45,044	2,467	(38,065)
Net Patient Service Revenue	**7,363,514**	**6,393,187**	**5,652,661**	**7,704,549**	**9,949,538**	**6,142,004**	**9,651,912**	**8,362,915**	**98,586,335**	**82,948,702**	**1,288,997**	**15,637,633**
CNR%	**43%**	**43%**	**33%**	**43%**	**48%**	**39%**	**47%**	**46%**	**47%**	**45%**	**1%**	**2%**
Cost of Services - Direct												
Salaries and Wages	2,516,276	1,959,005	2,677,613	2,511,015	2,792,227	2,962,848	2,867,100	2,543,864	30,485,898	25,555,539	323,236	4,930,359
Benefits	1,537,835	1,681,176	1,490,439	1,831,123	2,146,672	1,865,932	1,340,313	1,780,302	16,200,544	19,083,171	(439,988)	(2,882,627)
Professional Fees	1,623,461	1,942,950	1,976,553	1,716,884	1,780,229	1,923,375	1,979,333	1,615,480	19,746,332	18,736,042	363,853	1,010,290
Contract Labor	405,743	219,870	364,547	788,024	205,329	500,915	952,538	401,571	4,727,868	8,138,884	550,967	(3,411,016)
Pharmacy	474,631	327,171	442,678	333,474	656,870	224,919	400,601	(96,169)	4,963,691	3,089,008	496,770	1,874,683
Medical Supplies	218,356	203,442	642,449	485,465	352,626	466,240	345,474	324,135	5,174,423	4,430,086	21,339	744,337
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	126,094	138,908	(768,589)	160,195	16,399	147,652	17,826	330,555	258,114	1,846,503	(312,729)	(1,588,389)
Other Direct Expenses	696,431	531,119	834,238	651,545	571,418	530,520	562,883	495,250	7,300,101	6,667,088	67,633	633,013
Total Cost of Services - Direct	7,598,828	7,003,641	7,659,929	8,477,724	8,521,770	8,622,401	8,466,067	7,394,987	88,856,971	87,546,322	1,071,080	1,310,650
General and Administrative Overhead												
Salaries and Wages	427,743	368,344	494,737	458,763	547,877	520,721	444,697	426,210	5,155,436	4,400,151	18,487	755,286
Benefits	264,414	272,374	284,918	2,870,040	346,888	367,789	231,676	223,735	2,733,172	5,656,553	7,941	(2,923,381)
Professional Fees	344,426	278,757	451,329	260,367	153,271	403,951	222,585	525,104	2,713,469	3,534,436	(302,519)	(820,967)
Contract Labor	24,000	27,901	63,611	27,375	114,784	21,225	16,409	62,613	522,474	399,685	(46,204)	122,788
Depreciation and Amortization	386,783	344,315	1,264,318	341,803	438,198	326,475	447,841	337,294	5,058,443	3,726,266	110,547	1,332,177
Other Administative Expenses	142,398	172,710	258,954	163,103	336,216	182,837	175,162	202,135	2,140,437	1,941,670	(26,974)	198,767
Total General and Administrative Overhead	1,589,765	1,464,400	2,817,866	4,121,641	1,937,234	1,822,998	1,538,370	1,777,092	18,323,431	19,658,952	(238,722)	(1,335,521)
Total Expenses	**9,188,592**	**8,468,041**	**10,477,795**	**12,599,365**	**10,459,004**	**10,445,400**	**10,004,437**	**9,172,079**	**107,180,402**	**107,205,274**	**832,358**	**(24,871)**
Financing Expense	184,336	172,904	345,952	180,509	197,249	178,979	209,254	183,480	2,195,815	1,986,886	25,774	208,929
Financing Income	228,125	247,716	228,125	247,716	228,125	247,716	228,125	247,716	2,509,370	2,724,874	(19,591)	(215,504)
Investment Income	(105,802)	41,183	39,189	40,992	164,066	158,772	46,777	56,107	675,063	667,964	(9,330)	7,099
Miscellaneous Income	9,178,896	1,810,358	342,474	5,590,718	121,862	236,130	250,735	137,633	11,425,043	10,876,349	113,102	548,693
Net Income (Change in Financial Position)	**7,291,804**	**(148,502)**	**(4,561,299)**	**803,710**	**(192,661)**	**(3,839,657)**	**(36,142)**	**(551,189)**	**3,819,593**	**(11,974,561)**	**515,047**	**15,794,154**
Operating Income	(1,825,078)	(2,074,854)	(4,825,134)	(4,894,817)	(509,466)	(4,303,296)	(352,524)	(809,164)	(8,594,067)	(24,256,472)	456,639	15,662,404
EBITDA	7,678,588	195,813	(3,296,981)	1,145,512	245,536	(3,513,182)	411,699	(888,483)	8,878,036	(8,248,295)	1,300,181	17,126,331
Net Profit Margin	99.0%	-2.3%	-80.7%	10.4%	-1.9%	-62.5%	-0.4%	-6.6%	3.9%	-14.4%	6.2%	18.3%
Operating Margin	-24.8%	-32.5%	-85.4%	-63.5%	-5.1%	-70.1%	-3.7%	-9.7%	-8.7%	-29.2%	6.0%	20.5%
EBITDA Margin	104.3%	3.1%	-58.3%	14.9%	2.5%	-57.2%	4.3%	-10.6%	9.0%	-9.9%	14.9%	109.5%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2024

	PY Balances	2/29/2024	2/28/2023	3/31/2024	3/31/2023	4/30/2024	4/31/2023	5/31/2024	5/31/2023	MOM Change	Prior Year Change
Assets											
Current Assets											
Cash and Liquid Capital	17,558,072	8,770,199	7,914,764	12,778,438	10,502,555	8,030,005	13,568,674	21,374,165	16,815,088	13,344,160	4,559,077
Short Term Investments	10,497,077	6,335,363	10,418,390	6,336,695	10,410,937	6,412,401	10,506,281	6,414,343	10,501,488	1,942	(4,087,145)
PMA Partnership	-	-	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	14,932,580	19,458,681	19,699,808	12,458,272	20,562,360	17,119,074	14,264,930	13,540,975	9,681,108	(3,578,099)	3,859,867
Other Receivables	3,244,845	19,050,631	9,308,827	18,203,532	9,317,329	17,139,611	9,679,612	7,531,522	10,166,066	(9,608,089)	(2,634,544)
Inventory	5,159,474	5,158,222	3,063,026	5,162,663	3,089,267	5,200,224	3,081,283	5,203,267	3,062,773	3,043	2,140,495
Prepaid Expenses	1,793,630	1,276,680	1,401,834	1,744,260	1,333,985	1,583,016	1,241,525	1,192,179	1,185,652	(390,836)	6,527
Total Current Assets	**53,185,677**	**60,049,776**	**51,806,650**	**56,683,861**	**55,216,432**	**55,484,330**	**52,342,303**	**55,256,452**	**51,412,175**	**(227,878)**	**3,844,276**
Assets Limited as to Use											
Internally Designated for Capital Acquisitions	-	-	-	-	-	-	-	-	-	-	-
Short Term - Restricted	1,466,355	1,467,283	1,446,108	1,467,411	1,466,171	1,467,535	1,466,232	1,467,662	1,466,295	128	1,368
Limited Use Assets										-	-
LAIF - DC Pension Board Restricted	798,218	-	778,293	-	785,746	-	789,013	-	793,806	-	(793,806)
LAIF - DB Pension Board Restricted	15,684,846	15,684,846	19,296,858	15,684,846	19,296,858	15,684,846	19,296,858	15,684,846	19,296,858	-	(3,612,012)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	-	573,097	-	573,097		573,097	-	-	573,097
Total Limited Use Assets	17,056,161	16,257,943	20,075,151	16,257,943	20,082,604	16,257,943	20,085,871	16,257,943	20,090,664	-	(3,832,721)
Revenue Bonds Held by a Trustee	1,078,187	1,051,852	1,081,516	1,046,147	1,075,802	962,817	1,070,092	957,113	1,083,896	(5,704)	(126,783)
Total Assets Limited as to Use	**19,600,703**	**18,777,078**	**22,602,775**	**18,771,501**	**22,624,577**	**18,688,294**	**22,622,196**	**18,682,718**	**22,640,855**	**(5,576)**	**(3,958,136)**
Long Term Assets											
Long Term Investment	2,767,655	1,831,779	2,744,893	1,832,199	2,752,606	1,834,470	2,771,350	1,840,643	2,761,001	6,174	(920,358)
Fixed Assets, Net of Depreciation	85,078,613	85,151,277	76,485,894	84,393,675	76,673,974	84,323,364	76,823,477	84,562,800	77,195,012	239,437	7,367,788
Total Long Term Assets	**87,846,268**	**86,983,056**	**79,230,787**	**86,225,875**	**79,426,580**	**86,157,833**	**79,594,827**	**86,403,444**	**79,956,013**	**245,610**	**6,447,430**
Total Assets	**160,632,647**	**165,809,910**	**153,640,212**	**161,681,236**	**157,267,589**	**160,330,458**	**154,559,326**	**160,342,614**	**154,009,043**	**12,156**	**6,333,570**
Liabilities											
Current Liabilities											
Current Maturities of Long-Term Debt	4,932,910	3,849,316	957,628	3,907,233	901,673	3,883,529	875,213	4,167,637	848,672	284,108	3,318,965
Accounts Payable	5,088,334	4,346,694	5,482,703	5,131,234	5,186,458	4,047,103	6,096,323	4,728,733	5,933,534	681,630	(1,204,801)
Accrued Payroll and Related	8,318,121	7,226,154	5,321,872	7,439,170	5,913,994	7,585,529	5,850,013	7,216,488	6,742,378	(369,041)	474,109
Accrued Interest and Sales Tax	92,441	238,080	238,573	314,125	310,734	140,964	119,257	39,126	194,008	(101,838)	(154,882)
Notes Payable	1,532,689	1,035,689	2,133,708	931,738	2,133,708	931,738	2,133,708	446,860	1,633,671	(484,877)	(1,186,811)
Unearned Revenue	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(1,812)	(4,542)	662	(4,542)	2,474	5,204
Due to 3rd Party Payors	693,247	693,247	478,242	693,247	262,335	693,247	693,247	693,247	693,247	-	-
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	1,942,292	1,925,736	2,146,080	1,923,666	2,146,080	1,921,596	2,146,080	1,919,527	2,146,080	(2,070)	(226,553)
Total Current Liabilities	**22,595,491**	**19,310,372**	**16,754,263**	**20,335,871**	**16,850,439**	**19,201,894**	**17,909,298**	**19,212,280**	**18,187,048**	**10,386**	**1,025,232**
Long Term Liabilities											
Long Term Debt	37,511,965	36,545,985	33,455,530	35,863,988	33,455,530	36,434,249	33,455,530	36,382,902	33,455,530	(51,347)	2,927,372
Bond Premium	203,263	178,166	215,811	175,029	212,674	171,892	209,537	168,755	206,400	(3,137)	(37,645)
Accreted Interest	16,540,170	17,302,780	16,743,218	17,396,138	16,838,349	16,804,350	16,933,481	16,897,707	17,028,613	93,358	(130,906)
Other Non-Current Liability - Pension	47,257,663	47,257,663	47,821,876	47,257,663	50,366,473	47,257,663	50,366,473	47,257,663	50,366,473	-	(3,108,810)
Total Long Term Liabilities	**101,513,061**	**101,284,595**	**98,236,435**	**100,692,818**	**100,873,027**	**100,668,154**	**100,965,022**	**100,707,028**	**101,057,016**	**38,874**	**(349,989)**
Suspense Liabilities	-	-	-	-	-	-		-		-	
Uncategorized Liabilities (grants)	44,693	124,918	615,594	123,693	686,039	124,093	681,315	122,993	676,582	(1,100)	(553,589)
Total Liabilities	**124,153,245**	**120,719,885**	**115,606,292**	**121,152,382**	**118,409,505**	**119,994,141**	**119,555,635**	**120,042,301**	**119,920,646**	**48,160**	**121,655**
Fund Balance											
Fund Balance	45,515,489	35,013,047	43,831,306	35,013,047	43,831,306	35,013,047	43,831,306	35,013,057	43,831,306	10	(8,818,250)
Temporarily Restricted	1,466,354	1,467,283	2,590,039	1,467,411	2,610,102	1,467,535	2,610,163	1,467,662	2,610,225	128	(1,142,563)
Net Income	(10,502,442)	8,609,695	(8,387,425)	4,048,396	(7,583,324)	3,855,735	(11,437,779)	3,819,593	(12,353,135)	(36,142)	16,172,728
Total Fund Balance	**36,479,402**	**45,090,025**	**38,033,921**	**40,528,854**	**38,858,084**	**40,336,317**	**35,003,690**	**40,300,313**	**34,088,397**	**(36,004)**	**6,211,915**
Liabilities + Fund Balance	**160,632,647**	**165,809,910**	**153,640,212**	**161,681,236**	**157,267,589**	**160,330,458**	**154,559,326**	**160,342,614**	**154,009,043**	**12,156**	**6,333,570**
(Decline)/Gain		7,268,230	(1,263,649)	(4,128,674)	3,627,377	(1,350,778)	(2,708,264)	12,156	(550,282)	1,362,934	562,438
	0	0	0	0	0	0	0	0	0	0	0

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2024

Calculation method agrees to SECOND and THIRD SUPPLEMENTAL INDENTURE OF TRUST 2021 Bonds Indenture

Long-Term Debt Service Coverage Ratio Calculation

Numerator:	HOSPITAL FUND ONLY	
Excess of revenues over expense	$ 3,819,593	11 months of earnings
+ Depreciation Expense	5,058,443	
+ Interest Expense	2,195,815	
Less GO Property Tax revenue	1,611,787	
Less GO Interest Expense	470,196	
"Income available for debt service" *(definition per 2010 and 2013 and 2021 Indenture)*	**$ 8,991,868**	
Denominator:		
Supplemental Indenture of Trust)		
2021A Revenue Bonds	$ 112,700	
2021B Revenue Bonds	905,057	
2009 GO Bonds (Fully Accreted Value)		
2016 GO Bonds		
Financed purchases and other loans	1,704,252	
Total **Maximum Annual Debt Service**	**$ 2,722,009**	Full year of debt
	2,495,175	YTD debt
Ratio: (numerator / denominator)	**3.60**	YTD debt service coverage
Required Debt Service Coverage Ratio:	1.10	
In Compliance? (Y/N)	**Yes**	

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	$ 27,788,508
Cash and Investments-non current	1,840,643
Sub-total	29,629,151
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	(957,113)
Building and Nursing Fund	(1,467,662)
Total Unrestricted Funds	**$ 27,204,376**
Total Operating Expenses	$ 107,180,402
Less Depreciation	5,058,443
Net Expenses	102,121,959
Average Daily Operating Expense	$ 303,934
Days Cash on Hand	**90**

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2024

CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts from and on Behalf of Patients	$	99,131,121
Payments to Suppliers and Contractors		(39,368,919)
Payments to and on Behalf of Employees		(59,825,391)
Other Receipts and Payments, Net		(926,304)
Net Cash Provided (Used) by Operating Activities		(989,493)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Noncapital Contributions and Grants		10,210,909
Property Taxes Received		897,583
Payments on CHFFA Loans		(981,877)
Other		-
Net Cash Provided (Used) by Noncapital Financing Activities		10,122,869
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES		
Principal Payments on Long-Term Debt		(3,496,378)
Proceeds from the Issuance of Refunding Revenue Bonds		-
Payment to Defease Revenue Bonds		-
Interest Paid		(2,195,815)
Purchase and Construction of Capital Assets		(5,058,443)
Payments on Lease Liability		(80,186)
Payments on Subscription Liability		(864,632)
Property Taxes Received		1,611,787
Net Cash Provided (Used) by Capital and Capital Related Financing Activities		(10,083,667)
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment Income		675,063
Rental Income		8,589
Net Cash Provided (Used) by Investing Activities		683,652
NET CHANGE IN CASH AND CASH EQUIVALENTS		(266,640)
Cash and Cash Equivalents - Beginning of Year		28,055,148
CASH AND CASH EQUIVALENTS - END OF YEAR	$	27,788,508

Key Financial Performance Indicators	Industry Benchmark	May-23	Jun-23	FYE 2023 Average	Feb-24	Mar-24	Apr-24	May-24	Variance to Prior Month	Variance to FYE 2023 Average	Variance to Prior Year Month	Variance to Benchmark	Reduction Target	Comment
Volume														
Admits	41	78	83	68	77	74	63	86	23	18	8	45		Mammoth monthly average in 2022 per HCAI
Deliveries	n/a	19	17	17	20	16	15	22	7	5	3	n/a		
Adjusted Patient Days	n/a	1,190	1,105	984	940	895	1,161	1,203	42	219	13	n/a		
Total Surgeries	153	123	81	120	133	143	148	140	(8)	20	17	(13)		Mammoth monthly average in 2022 per HCAI
ER Visits	659	815	851	810	753	780	856	896	40	86	81	237		Mammoth monthly average in 2022 per HCAI
RHC and Clinic Visits	n/a	4,557	4,381	4,353	4,246	4,556	3,129	4,999	1,870	646	442	n/a		
Diagnostic Imaging Services	n/a	2,191	2,051	2,020	1,953	2,038	2,250	2,293	43	273	102	n/a		
Rehab Services	n/a	949	896	762	690	699	835	311	(524)	(451)	(638)	n/a		
AR & Income														
Gross AR (Cerner only)	n/a	$ 50,856,137	$ 50,668,396	$ 53,638,580	$ 55,489,238	$ 48,964,677	$ 52,118,365	$ 53,102,112	$ 983,748	$ (536,467)	$ 2,245,976	n/a		
AR > 90 Days	$ 7,688,895.45	$ 26,738,034	$ 25,752,910	$ 23,440,542	$ 27,534,816	$ 22,242,405	$ 21,921,549	$ 22,672,126	$ 750,577	$ (768,416)	$ (4,065,908)	$ 14,983,231	(14,983,231)	15% of gross AR is benchmark
AR % > 90 Days	15%	51.45%	51.55%	45.3%	50.37%	46.22%	42.77%	43.41%	0.6%	-1.9%	-8.0%	28.4%		Industry average
AR Days	43.00	92.92	89.78	91.35	87.7	78.7	83.7	82.1	(1.56)	(9.25)	(10.82)	39.10		California CAH
Net AR	n/a	$ 9,681,108	$ 9,351,360	$ 17,800,084	$ 19,458,681	$ 12,458,272	$ 17,119,074	$ 13,540,975	$ (3,578,099)	$ (4,259,109)	$ 3,859,867	n/a		
Net AR % of Gross	n/a	19.0%	18.5%	33.1%	35.1%	25.4%	32.8%	25.5%	-7.3%	-7.6%	6.5%	n/a		
Gross Patient Revenue/Calendar Day	n/a	$ 585,271	$ 543,011	$ 546,652	$ 595,966	$ 556,918	$ 687,640	$ 656,765	$ (30,874)	$ 110,114	$ 71,494	n/a		
Net Patient Revenue/Calendar Day	n/a	$ 269,771	$ 198,702	$ 243,317	$ 253,914	$ 182,344	$ 331,651	$ 311,352	$ (20,299)	$ 68,035	$ 41,581	n/a		
Net Patient Revenue/APD	n/a	$ 7,028	$ 5,395	$ 7,622	$ 7,834	$ 6,316	$ 8,570	$ 8,023	$ (547)	$ 401	$ 996	n/a		
Wages														
Wages	n/a	$ 3,154,215	$ 5,954,820	$ 3,281,173	$ 2,944,019	$ 3,172,350	$ 3,340,105	$ 3,311,797	$ (28,308)	$ 30,624	$ 157,582	n/a		
Employed paid FTEs	n/a	364.62	364.62	384.63	346.25	348.17	367.13	357.91	(9.22)	(26.72)	(6.71)	n/a	-2%	
Employed Average Hourly Rate	$ 38.00	$ 48.83	$ 95.27	$ 48.51	$ 51.31	$ 51.44	$ 53.07	$ 52.24	$ (0.84)	$ 3.72	$ 3.40	$ 14.24		According to California Hospital Association data
Benefits	n/a	$ 1,819,896	$ 1,610,167	$ 1,907,194	$ 1,802,249	$ 1,775,357	$ 2,493,560	$ 1,571,990	$ (921,570)	$ (335,204)	$ (247,906)	n/a		
Benefits % of Wages	30%	57.7%	27.0%	58.7%	61.2%	56.0%	74.7%	47.5%	-27.2%	-11.2%	-10.2%	17.5%	(315,184)	Industry average
Contract Labor	n/a	$ 821,563	$ 803,281	$ 808,284	$ 429,743	$ 428,159	$ 320,113	$ 968,946	$ 648,833	$ 160,662	$ 147,383	n/a		
Contract Labor Paid FTEs	n/a	37.94	39.55	40.27	23.86	23.27	21.07	29.72	8.65	(10.55)	(8.22)	n/a		
Total Paid FTEs	n/a	402.56	404.17	424.90	370.11	371.44	388.20	387.63	(0.57)	(37.27)	(14.93)	n/a		
Contract Labor Average Hourly Rate	$ 81.04	$ 122.24	$ 118.48	$ 112.84	$ 108.69	$ 103.86	$ 88.62	$ 184.04	$ 95.42	$ 71.20	$ 61.80	$ 103.00	$ (424,649)	Per zip recruiter as of August 2023 for California, higher range is benchmark
Total Salaries, Wages, & Benefits	n/a	$ 5,795,674	$ 8,368,268	$ 5,996,651	$ 5,176,011	$ 5,375,866	$ 6,153,778	$ 5,852,733	$ (301,045)	$ (143,918)	$ 57,059	n/a		
SWB% of NR	50%	69.3%	140.4%	79.8%	70.3%	95.1%	61.8%	60.6%	-1.2%	-19.1%	-8.7%	$ 0	$ (591,023)	Per Becker Healthcare, max should be 50%
SWB/APD	2,613	$ 4,870	$ 7,573	$ 5,912	$ 5,506	$ 6,007	$ 5,300	$ 4,865	$ (435)	$ (1,047)	$ (5)	$ 2,252	$ (11,297)	Industry average
SWB % of total expenses	50%	63.8%	92.2%	66.0%	56.3%	51.3%	58.8%	58.5%	-0.3%	-7.5%	-5.3%	9%	$ (890,756)	Industry average
									0	0	0			
Physician Spend									0	0	0			
Physician Expenses	n/a	$ 1,229,279	$ 1,428,974	$ 1,400,634	$ 1,378,852	$ 1,724,855	$ 1,591,311	$ 1,780,354	$ 189,043	$ 379,720	$ 551,075	n/a		
Physician expenses/APD	n/a	$ 1,033	$ 1,293	$ 1,451	$ 1,467	$ 1,927	$ 1,371	$ 1,480	$ 109	$ 29	$ 447	n/a		
									$ -	$ -	$ -			
Supplies									0	0	0			
Supply Expenses	n/a	$ 227,784	$ (985,032)	$ 544,557	$ 692,988	$ 1,085,127	$ 1,009,496	$ 746,075	$ (263,421)	$ 201,518	$ 518,291	n/a		
Supply expenses/APD	n/a	$ 191	$ (891)	$ 579	$ 737	$ 1,212	$ 870	$ 620	$ (249)	$ 42	$ 429	n/a		
									$ -	$ -	$ -			
Other Expenses									0	0	0			
Other Expenses	n/a	$ 1,827,709	$ 268,236	$ 1,138,604	$ 1,940,741	$ 2,291,947	$ 1,704,419	$ 1,625,275	$ (79,144)	$ 486,672	$ (202,434)	n/a		
Other Expenses/APD	n/a	$ 1,536	$ 243	$ 1,178	$ 2,065	$ 2,561	$ 1,468	$ 1,351	$ (117)	$ 173	$ (185)	n/a		
									0	0	0			
Margin									0	0	0			
Net Income	n/a	$ (915,356)	$ (5,031,592)	$ (1,448,727)	$ 7,291,804	$ (4,561,299)	$ (192,661)	$ (36,142)	$ 156,520	$ 1,412,586	$ 879,214	n/a		
Net Profit Margin	n/a	-10.9%	-84.4%	-20.8%	99.0%	-80.7%	-1.9%	-0.4%	1.6%	20.4%	10.5%	n/a		
Operating Income	n/a	$ (1,173,331)	$ (5,308,483)	$ (2,495,327)	$ (1,825,078)	$ (4,825,134)	$ (509,466)	$ (352,524)	$ 156,941	$ 2,142,802	$ 820,807	n/a		
Operating Margin	2.9%	-14.0%	-89.1%	-33.0%	-24.8%	-85.4%	-5.1%	-3.7%	1.5%	29.3%	10.3%	-6.6%		Per Kaufman Hall September Natitonal Hospital Flash
EBITDA	n/a	$ (1,259,806)	$ (5,370,917)	$ (1,789,289)	$ 7,678,588	$ (3,296,981)	$ 245,536	$ 411,699	$ 166,162	$ 2,200,988	$ 1,671,505	n/a		
EBITDA Margin	12.7%	-15.1%	-90.1%	-22.6%	104.3%	-58.3%	2.5%	4.3%	1.8%	26.9%	19.4%	-8.4%		CLA critical access hospitals
Debt Service Coverage Ratio	3.70		(5.8)	(5.8)	6.3	4.1	3.8	3.6	(0.18)	9.41	3.60	(0.10)		Per bond requirement, need to be at 1.1
									0	0	0			
Cash									0	0	0			
Avg Daily Disbursements (excl. IGT)	n/a	$ 363,468	$ 489,123	$ 363,636	$ 390,998	$ 399,030	$ 382,730	$ 342,362	$ (40,369)	$ (21,274)	$ (21,106)	n/a	$ (79,351)	-7%
Average Daily Cash Collections (excl. IGT)	n/a	$ 423,206	$ 482,340	$ 340,919	$ 307,834	$ 319,679	$ 352,222	$ 294,096	$ (58,126)	$ (46,823)	$ (129,110)	n/a	$ 79,351	-36%
Average Daily Net Cash		$ 59,738	$ (6,783)	$ (22,716)	$ (83,164)	$ (79,351)	$ (30,508)	$ (48,265)	$ (17,757)	$ (25,549)	$ (108,004)	n/a	$ 79,351	-228%
Unrestricted Funds	n/a	$ 26,740,594	$ 31,636,319	$ 25,185,410	$ 15,105,562	$ 19,115,133	$ 14,442,406	$ 27,788,508	$ 13,346,102	$ 2,603,098	$ 1,047,914	n/a		4%
Change of cash per balance sheet	n/a	$ 1,851,890	$ 4,895,725	$ 204,360	$ (3,782,743)	$ 4,009,571	$ (4,672,727)	$ 13,346,102	$ 18,018,829	$ 13,141,742	$ 11,494,212			
Days Cash on Hand (assume no more cash is collected)	196	91	105	83	48	61	46	90	44	7	(1)	n/a		Per bond requirement, we need 75 minimum. Other California CAH average 196
Estimated Days Until Depleted		-	4,664	1,109	169	156	160	1,937	1,776	828	1,937	n/a		
Years Until Cash Depletion		-	12.78	3.04	0.46	0.43	0.44	5.31	4.87	2.27	5.31	n/a		

Northern Inyo Healthcare District
May 2024 – Financial Summary

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Net Income (Loss)	(36,142)	(551,189)	(937,096)	515,047	900,955	3,819,593	(11,974,561)	(16,087,999)	15,794,154	19,907,592	93%	132%	124%
Operating Income (Loss)	(352,524)	(809,164)	(838,191)	456,639	485,667	(8,594,067)	(24,256,472)	(12,873,730)	15,662,404	4,279,663	56%	65%	33%
EBITDA (Loss)	411,699	(888,483)	(880,341)	1,300,181	1,292,040	8,878,036	(8,248,295)	(15,398,383)	17,126,331	24,276,420	146%	208%	158%

Income is favorable for the month due to favorable net patient revenue compared to prior year. This is due to an increase in volume in several areas which was partially offset by higher expenses in supplies, wages, benefits, insurance, and utilities.

IP Gross Revenue	3,646,287	3,261,629	3,198,650	384,658	447,637	38,554,203	34,660,937	32,394,947	3,893,266	6,159,256	12%	11%	19%
OP Gross Revenue	14,890,447	13,355,732	13,005,993	1,534,715	1,884,454	152,183,966	133,144,537	135,274,870	19,039,429	16,909,096	11%	14%	12%
Clinic Gross Revenue	1,822,994	1,526,050	1,467,097	296,944	355,897	17,723,375	15,509,478	14,335,480	2,213,897	3,387,895	19%	14%	24%
Net Patient Revenue	9,651,912	8,362,915	7,432,812	1,288,997	2,219,100	98,586,335	82,948,702	76,561,283	15,637,633	22,025,052	15%	19%	29%
Cash Net Revenue % of Gross	47%	46%	42%	1%	5%	47%	45%	42%	2%	5%	3%	5%	12%

Gross Revenue increased $2.2M due to volumes increasing. For the year, gross revenue increased $25M. Net revenue is slightly higher as a % of gross revenue due to less aging (>270 days) AR.

Admits (excl. Nursery)	86	78		8		785	755		30		10%	4%	
IP Days	266	244		22		2,339	2,293		46		9%	2%	
IP Days (excl. Nursery)	237	214		23		2,073	2,017		56		11%	3%	
Average Daily Census	7.64	6.90		0.73		6.17	6.02		0.15		11%	2%	
ALOS	2.75	2.74		0.01		2.64	2.67		(0.03)		0%	-1%	
Deliveries	22	19		3		178	185		(7)		16%	-4%	
OP Visits	3,461	3,962		(501)		39,197	39,989		(792)		-13%	-2%	
RHC Visits	3,143	2,681		462		32,949	29,201		3,748		17%	13%	
Rural Health Clinic Visits	2,462	2,035		427		25,950	23,362		2,588		21%	11%	
Rural Health Women Visits	536	485		51		5,232	4,895		337		11%	7%	
Rural Health Behavioral Visits	145	161		(16)		1,767	944		823		-10%	87%	
NIA Clinic Visits	1,856	1,877		(21)		17,742	18,696		(954)		-1%	-5%	
Bronco Clinic Visits	63	50		13		390	356		34		26%	10%	
Internal Medicine Clinic Visits	-	402		(402)		201	3,975		(3,774)		-100%	-95%	
Orthopedic Clinic Visits	415	384		31		3,825	3,594		231		8%	6%	
Pediatric Clinic Visits	630	610		20		6,805	6,229		576		3%	9%	
Specialty Clinic Visits	559	307		252		4,512	3,014		1,498		82%	50%	
Surgery Clinic Visits	129	79		50		1,434	1,043		391		63%	37%	
Virtual Care Clinic Visits	60	45		15		575	485		90		33%	19%	
Surgeries IP	15	27		(12)		218	210		8		-44%	4%	
Surgeries OP	125	96		29		1,382	1,113		269		30%	24%	
Total Surgeries	140	123		17		1,600	1,323		277		14%	21%	
Cardiology	1	-		-		2	-		2		0%	0%	
General	68	63		5		783	575		208		8%	36%	
Gynecology & Obstetrics	17	10		7		172	134		38		70%	28%	
Ophthalmology	18	3		15		246	263		(17)		500%	-6%	
Orthopedic	23	42		(19)		275	322		(47)		-45%	-15%	
Pediatric	-	-		-		-	1		(1)		0%	-100%	
Podiatry	-	-		-		1	3		(2)		0%	-67%	
Urology	13	5		8		121	25		96		160%	384%	
Diagnostic Imaging	2,293	2,191		102		23,011	22,189		822		5%	4%	
Emergency Visits	896	793		103		9,201	8,891		310		13%	3%	
ED Admits	49	32		17		389	360		29		53%	8%	
ED Admits % of ED Visits	5.5%	4.0%		1.4%		4.2%	4.0%		0.2%		36%	4%	
Rehab	311	949		(638)		6,612	8,252		(1,640)		-67%	-20%	
Nursing Visits	376	227		149		3,312	2,696		616		66%	23%	
Observation Hours	1,225	1,733		(508)		20,742	19,760		982		-29%	5%	

Not Available

Admissions are up 10% compared to last May and 4% for the year. Total surgeries are 14% higher than last May and 21% higher for the year. This is due to added surgeons in general and urology. RHC & clinic volumes have increased in all areas due to efficiencies and added providers. ER and DI services have increased 3% & 4% over prior year. Nursing visits have increased 23% year over year due to increased infusions and wound care.

Payor mix													
Blue Cross	28.5%	23.8%		4.7%		27.3%	26.6%		0.7%		20%	3%	
Commercial	5.3%	6.3%		-1.0%		5.3%	6.3%		-1.0%		-17%	-16%	
Medicaid	19.1%	23.9%		-4.8%		19.5%	21.8%		-2.3%		-20%	-11%	
Medicare	39.7%	42.5%	N/A	-2.8%	N/A	42.7%	41.0%	N/A	1.7%	N/A	-7%	4%	N/A

Northern Inyo Healthcare District
May 2024 – Financial Summary

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Self-pay	2.7%	1.9%		0.8%		2.9%	2.5%		0.4%		41%	14%	
Workers' Comp	1.2%	1.3%		-0.2%		1.3%	1.3%		0.1%		-11%	4%	
Other	3.6%	0.2%		3.4%		1.0%	0.5%		0.5%		1632%	108%	
DEDUCTIONS													
Contract Adjust	9,761,982	8,271,575	9,539,376	1,490,407	222,606	103,077,386	86,463,310	98,243,136	16,614,077	4,834,250	18%	19%	5%
Bad Debt	538,525	1,264,180	349,776	(725,655)	188,749	1,663,671	8,885,782	3,600,439	(7,222,111)	(1,936,768)	-57%	-81%	-54%
Write-off	410,472	245,437	349,776	165,035	60,696	5,141,131	5,062,202	3,600,439	78,929	1,540,692	67%	2%	43%

For the month, payor mix shifted to Blue Cross from Commerical, Medicaid, and Medicare which has better reimbursement. For the year, payor mix has slightly shifted from Medicaid to Self Pay & Other

DENIALS

Denials increased $1.2M from the 6-month average but are still $600k below the baseline.

CHARITY	-	209	-	(209)	-	37,364	393,677	-	(356,313)		-100%	-91%	

Charity discounts have decreased compared to prior year due to policy update

BAD DEBT

Bad debt write offs were $591k which is $100k lower than year-to-date average

CASH

Cash for May was favorable by $12.8M due to receiving $14.3M in IGT and tax appropriations from the county. Excluding IGT and tax appropriations, cash deficit was $1.5M or $48k per day. For the year, including IGT, we are at a cash deficit of $11k per day and $49k per day excluding grants, IGT, and tax appropriations.

CENSUS

Patient Days	266	244		22		2,339	2,293		46		9%	2%	
Adjusted Days	1,203	1,357		(155)		12,449	11,123		1,326		-11%	12%	
Employed Paid FTE	357.91	364.62		(6.71)		353.70	391.51		(37.81)		-2%	-10%	
Contract Paid FTE	29.72	37.94	N/A	(8.22)	N/A	27.58	49.19	N/A	(21.61)	N/A	-22%	-44%	N/A
Total Paid FTE	387.63	402.57		(14.93)		381.27	440.70		(59.43)		-4%	-13%	
EPOB (Employee per Occupied Bed)	1.42	1.74		(0.33)		1.40	2.02		(0.62)		-19%	-31%	
Adjusted EPOB	0.25	0.31		(0.06)		0.26	0.38		(0.12)		-19%	-32%	

SALARIES

Per Adjust Bed Day	$ 2,754	$ 2,188		$ 566		$ 2,863	$ 2,693		$ 170		26%	6%	
Total Salaries	$ 3,311,797	$ 2,970,074	$ 2,744,806	(143,464)	773,042	$ 35,641,334	$ 29,955,689	$ 29,228,032	5,343,922	5,846,312	-4%	20%	22%
Normalized Salaries (incl PTO used)	$ 3,311,797	$ 3,202,168	$ 2,744,806	(15,356)	773,042	$ 35,641,334	$ 32,130,489	$ 29,228,032	5,535,563	5,846,312	0%	21%	22%
Average Hourly Rate	$ 52.24	$ 49.58		$ 2.66		$ 52.48	$ 42.74		$ 9.74		5%	23%	
Employed Paid FTEs	357.91	364.62		(6.71)		353.70	391.51		(37.81)				

FTEs for the year declined compared to last year due to RIFFs. Average hourly rate increased due to raises.

BENEFITS

Per Adjust Bed Day	$ 1,307	$ 1,476		$ (169)		$ 1,521	$ 2,224		$ (703)		-11%	-32%	
Total Benefits	$ 1,571,990	$ 2,004,037	$ 2,080,426	$ (432,047)	(508,436)	$ 18,933,716	$ 24,739,723	$ 21,787,359	$ (2,853,643)	(2,853,643)	-22%	-12%	-13%
Benefits % of Wages	47%	67%	76%	-20%		53%	83%	75%	-29%		-30%	-36%	
Pension Expense	$ 290,559	$ 846,569	$ 839,400	$ (556,010)	(548,841)	$ 5,017,323	$ 11,903,427	$ 8,702,820	$ (3,685,497)	(3,685,497)	-66%	-31%	-42%
MDV Expense	$ 840,375	$ 567,787	$ 573,293	$ 272,588	267,082	$ 10,413,001	$ 6,015,639	$ 6,000,476	$ 4,412,525	4,412,525	48%	73%	74%
Payroll Taxes & WC insurance	$ 243,797	$ 233,722	$ 257,331	$ 10,075	(13,534)	$ 2,632,448	$ 2,431,954	$ 2,744,305	$ (111,857)	(111,857)	4%	-5%	-4%
PTO Incurred	$ -	$ 232,094	$ 152,428	$ (232,094)		$ -	$ 2,174,800	$ 1,610,786	$ 1,494,311		-100%	69%	
PTO Accrued	$ 111,616	$ 23,045	$ 152,428	$ 88,571	(40,812)	$ 68,705	$ 1,172,368	$ 1,610,786	$ (1,542,081)	(1,542,081)	384%	-132%	-96%
Reimbursements	$ -	$ -	$ -	$ -	-	$ -	$ -	$ -	$ -	-	0%	0%	0%
Sick	$ -	$ 314	$ 314	$ (314)	(314)	$ -	$ 161,567	$ 161,567	$ (161,567)	(161,567)	-100%	-100%	-100%
Other	$ 85,643	$ 100,506	$ 105,232	$ (14,863)	(19,589)	$ 802,239	$ 879,969	$ 956,620	$ (154,381)	(154,381)	-15%	-18%	-16%
Normalized Benefits	$ 1,571,990	$ 1,771,943	$ 1,927,998	$ (199,953)	(356,008)	$ 18,933,716	$ 22,564,923	$ 20,176,573	$ (3,631,207)	(1,242,857)	-11%	-16%	-6%
Normalized Benefits % of Wages	47%	55%	70%	-8%	-15%	53%	70%	69%	-17%	1%	-14%	-24%	2%

For the month, benefits as a % of wages is lower than prior year due to pension decreasing. For the year, benefits are consistent with prior year due to medical, dental, vision increasing and offsetting the savings from pension plan employee matching.

Northern Inyo Healthcare District
May 2024 – Financial Summary

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Salaries, Wages & Benefits	$ 4,883,787	$ 4,974,111	$ 4,672,804	$ (90,324)	210,983	$ 54,575,050	$ 54,695,412	$ 49,404,605	$ (120,363)	$ 5,170,445	-2%	0%	10%
SWB/APD	$ 4,061	$ 3,665		$ 396		$ 4,384	$ 4,917		$ (534)		11%	-11%	
SWB % of Total Expenses	48.8%	54.2%	56.5%	-5.4%	-8%	50.9%	51.0%	55.2%	-0.1%	-4%			

Total SWB for the month are lower than prior year de to less pension expense. For the year, SWB are flat with prior year due to merit increases offsetting FTE reductions and MDV expenses offsetting pension savings.

PROFESSIONAL FEES

Per Adjust Bed Day	$ 2,637	$ 1,919	$ 1,445	$ 718	1,192	$ 2,226	$ 2,770	$ -	$ (544)	$ 2,226	37%	-20%	
Total Physician Fee	$ 1,780,354	$ 1,229,279	$ 1,094,516	$ 551,075	685,838	$ 16,929,994	$ 15,378,635	$ 11,971,826	$ 1,551,359	$ 4,958,168	45%	10%	41%
Total Contract Labor	$ 968,946	$ 464,183	$ 353,804	$ 504,763	615,142	$ 5,250,341	$ 8,538,569	$ 3,858,913	$ (3,288,228)	$ 1,391,429	109%	-39%	36%
Total Other Pro-Fees	$ 421,564	$ 911,305	$ 512,970	$ (489,741)	$ (91,406)	$ 5,529,807	$ 6,891,844	$ 5,779,453	$ (1,362,037)	$ (249,646)	-54%	-20%	-4%
Total Professional Fees	$ 3,170,864	$ 2,604,767	$ 1,961,290	$ 566,097	1,209,574	$ 27,710,142	$ 30,809,048	$ 21,610,192	$ (3,098,906)	$ 6,099,951	22%	-10%	28%
Contract Paid FTEs	29.72	37.94		(8.22)		27.58	49.19		(21.61)		-22%	-44%	
Physician Fee per Adjust Bed Day	$ 1,480	$ 906		$ 575		$ 1,360	1,383		(23)				

Physician expense increase due to adding a general surgeon and urology. However, this is contributing to higher volumes and revenue. Contract labor was higher for the month due to accounting invoice corrections (prior month invoices paid in current month) but for the year is is lower due to reductions occurring. Other professional fees are lower than prior year due to the RSM revenue cycle project occuring this time last year.

PHARMACY

Per Adjust Bed Day	$ 333	$ (71)		$ 404		$ 399	$ 278		$ 121		-570%	44%	
Total Rx Expense	$ 400,601	$ (96,169)	$ 304,004	$ 496,770	96,597	$ 4,963,691	$ 3,089,633	$ 3,293,954	$ 1,874,059	$ 1,669,738	-517%	61%	51%

Accounting corrections in prior year caused this month to look higher compared to last May. For the year, expenses are higher due to volume and increased pricing along with higher utlization of high cost drugs

MEDICAL SUPPLIES

Per Adjust Bed Day	$ 287	$ 239		$ 48		$ 416	$ 398		$ 17		20%	4%	
Total Medical Supplies	$ 345,474	$ 324,135	$ 317,862	$ 21,339	27,612	$ 5,174,423	$ 4,430,086	$ 3,392,547	$ 744,337	$ 1,781,876	7%	17%	53%

Supplies are higher for the month and year due to higher volume and rising prices due to inflation.

EHR SYSTEM

Per Adjust Bed Day	$ 15	$ 244		$ (229)		$ 21	$ 166		$ (145)		-94%	-88%	
Total EHR Expense	$ 17,826	$ 330,555	$ 128,284	$ (312,729)	(110,459)	$ 258,114	$ 1,846,503	$ 1,384,304	$ (1,588,389)	$ (1,126,189)	-95%	-86%	-81%

Expense is lower than prior year and budget due to an accounting rule change that requires Cerner software to be listed as a right of use asset instead of expense.

OTHER EXPENSE

Per Adjust Bed Day	$ 614	$ 514		$ 100		$ 758	$ 774		$ (16)		19%	-2%	
Total Other	$ 738,045	$ 697,386	$ 830,003	$ 40,659	(91,959)	$ 9,440,538	$ 8,608,325	$ 9,659,798	$ 832,213	$ (219,260)	6%	10%	-2%

Other expenses are up due to higher utlities, insurance, and sales taxes on supplies which has increased.

DEPRECIATION AND AMORTIZATION

Per Adjust Bed Day	$ 372	$ 249		$ 124		$ 406	$ 335		$ 71		50%	21%	
Total Depreciation and Amortization	$ 447,841	$ 337,294	$ 56,756	$ 110,547	391,085	$ 5,058,443	$ 3,726,266	$ 689,615	$ 1,332,177	$ 4,368,828	33%	36%	634%

Amortization is higher due to a change in lease (GASB 87) and software accounting (GASB 96) requiring assets to be added for contracts and those assets are amortized over the life of the contract.

Total Expenses	$ 10,004,437	$ 9,172,079	$ 8,271,003	$ (504,763)	$ (615,142)	$ 107,180,402	$ 107,205,274	$ 89,435,013	$ 3,288,228	$ (1,391,429)	27%	10%	-8%
Per Adjust Bed Day	$ 8,319	$ 6,758		$ 1,561		$ 8,610	$ 9,638		$ (1,029)				
Per Calendar Day	$ 322,724	$ 295,874	$ 266,807	$ 26,850	55,917	$ 318,989	$ 320,016	$ 266,176	$ (1,026)	52,814	9%	0%	20%

For the month, expenses were higher due to SWB related to wage increases and benefits along with higher supplies due to volume and inflation along with higher insurance and utlities due to rising costs. For the year, expenses are consistent with prior year even though volume has grown meaning we are staffing more appropriately and being more efficient with our expenses.

Northern Inyo Healthcare District
www.nih.org

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811

Date: 07/09/2024
To: Board of Directors
From: J. Adam Hawkins, DO Chief Medical Officer
Re: Bi-Monthly CMO report

Medical Staff Department update

Project Updates:

- Rural Health Clinic Provider Template:
    - The main focus of my report for this month will revolve around the changes that have taken place within our Rural Health Clinic (RHC). Starting July 1st, our providers increased their patient appointment slots by approximately 10% per provider, per clinic day. On average, this will result in 14 more appointments available to our patients on a daily basis. This change was the culmination of months of collaboration and compromise between The District Administration and the providers in the RHC. A few notes on how and why we arrived at this change below:
        - Some logistical points of clarification: This change only impacts our providers delivering primary care in the RHC.
        - The modern delivery of healthcare in America often finds itself at a crossroads between optimizing operations to be financially solvent while asking the providers delivering the care to maintain a very high quality of care at the bedside level. As you can imagine, this is hard and rife with pitfalls. The District's financial struggles are well known to all that read this report. However, I am deeply proud that this District values the provider perspective and patient experience. Being financially solvent as a healthcare system means nothing if the care you are delivering is substandard. Conversely, delivering world class healthcare to your patients while not contributing to the financial stability of the overall system will ultimately result in negative patient outcomes at the logical conclusion of this dynamic. We were tasked with finding the delicate balance between these two forces. I believe what we have initiated is a massive step in the right direction.
        - The changes that have taken place will result in shorter appointment times for some encounters with our primary care physicians. However, we enlisted our providers in this decision at every point and arrived at appointment times that are well within standard of care of the industry and still allow meaningful discussion and connection between the providers and their patients.
        - At the end of the day, the space we have is limited. We are constantly evaluating how long our patients have to wait to see their primary care doctors for an appointment. We will continue to work to reduce the wait time while

maintaining the high quality experience our patients deserve when they show up for their appointments.
        - This change required diligent collaboration and buy-in from all departments involved. I want to thank the following individuals and departments for working to make this transition a reality: The clinical care teams in the RHC (providers, RN's, MA's), the patient access employees, the informatics and IT department, the compliance office, Barbara Laughon, Jannalyn Lawrence, Rosie Graves, & Tanya DeLeo.
- Toiyabe:
    - I met with the administrative leadership at Toiyabe in June. We discussed a variety of topics that could pose exciting opportunities for collaboration in the future. The ongoing struggle that we both continue to face is the ability to access patients electronic medical records across systems. This has wide-ranging clinical and operational implications. That being said, I am optimistic that granting some of their clinical providers "view-only" access to our EMR will be a step in the right direction to breakdown frustrating technological barriers that have existed between our organizations for far too long.
- Women's Services:
    - Saturday Women's Clinic: As you may recall, we made the operational decision to expand our women's clinic hours to include some Saturday coverage. This decision was made to accommodate increasing demand from patients having to travel long distances to receive care. As with all clinical initiatives, we are closely monitoring patient demand to make sure that the initiative is sustainable and meeting a community need. We have seen steady increases in volumes over the past month which have allowed us to carefully expand coverage. We hope to see this trend continue with the ultimate goal of providing a full day of Saturday clinic availability on a weekly basis.

Physician Recruitment update:

- Hospitalist Medicine: The Hospitalist Department will be welcoming Dr. David Lichtenfeld to their team starting at the end of this Summer. Dr. Lichtenfeld will be relocating to Bishop and providing near full-time coverage!

Quality Department update

- The Quality Department reported on NIHD's 2023 Quality Incentive Pool (QIP) Program results in mid-June. We reported the maximum number of metrics allowed, 12, and were fully successful in our performance.
- The QIP program is a State-level program focusing on the care of Medi-Cal patients, which we have been participating in since 2021. It provides specifications on over 50 clinical quality metrics, ranging from care of perinatal patients, management of diabetes, use of preventative screening tests (such as mammograms and colorectal cancer screenings), and pediatric care. National benchmarks are established for each measure, and to be successful the District must achieve at least the minimum benchmark and show year-over-year improvement on each measure reported. In 2023 we were one of very few hospitals striving for the maximum number of metrics.
- Last year we worked with clinical as well as front-office staff and launched a number of performance improvement projects across the District. Through this collaboration we were successful on 17 measures, and were able to pick which 12 to report to the State. The Quality Department is now preparing for an intensive audit of their work and results, which will continue through November. Once our scores are accepted, we anticipate receiving approximately $3.4 million from the State.
- The measures that we reported on are:
    1. Developmental Screening in the First Three Years
    2. Lead Screening in the First Two Years

3. Childhood Immunizations
4. Adolescent Immunizations
5. Prenatal Immunizations
6. Timeliness of Prenatal Visits
7. Timeliness of Postpartum Visits
8. Prenatal Depression Screening
9. Exclusive Breastfeeding
10. C-diff rates
11. Use of CTs in Minor Blunt Head Trauma
12. Breast Cancer Screening

- In addition, we were also successful in two diabetes measures, a cardiovascular care measure, advanced directives, and a transition of care measure.

Dietary Department

- Our former Director of Dietary services, Denice Hynd has agreed to rejoin the Distric in a leadership role! In June, Denice started as the Administrative Head of Dietary services at NIHD. She brings decades of clinical domain expertise, leadership experience, and familiarity with the unique needs of our District with her to this new position. She will provide desperately needed guidance for maintaining clinical excellence for our Dietary department and will ensure we are compliant with all regulatory requirements. She also has a depth of experience working with our Nutritional services department which is vital in ensuring the food that lands on our patients plate is thoughtfully constructed and up to date with the latest clinical recommendations.

Rehab Department

- In the near future this department will undergo significant operational changes that we hope will allow for more efficient and consistent clinical care for our patients. The details of the changes are beyond the scope of this report. However, I am very excited about the opportunity we as a District have to promote this department and the amazing clinical care that is being delivered by our therapists.

NORTHERN INYO HOSPITAL
Northern Inyo Healthcare District
150 Pioneer Lane, Bishop, California 93514

Medical Staff Office
(760) 873-2174 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: July 2, 2024
RE: Medical Executive Committee Report

The Medical Executive Committee met on this date. Following careful review and consideration, the Committee agreed to recommend the following to the NIHD Board of Directors:

A. Policies (*action item*)
   1. *Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program*
   2. *NIHD Antibiotic Stewardship Committee Charter*
   3. *NIHD Antibiotic Stewardship Program Plan*
   4. *Chaperone Use for Sensitive Exams*
   5. *Emergency Management Plan*
   6. *Mobile Intensive Care Nurse (MICN)*
   7. *DI – MRI Safety Plan*

B. Medical Staff Initial Appointments 2024-2025 (*action item*)
   1. Talia Luc, PMHNP (*psychiatric mental health nurse practitioner*) – APP staff
   2. Richard Thunder, MD (*orthopedic spine surgery*) – Courtesy Staff
   3. Jack Kornfeld, MD (*emergency medicine*) – Active Staff
   4. Bradley Clark, MD (*diagnostic radiology*) – Courtesy Staff
   5. Ann Marie Collier, MD (*neurology*) – Telemedicine Staff

C. Initial Proxy Credentialing for Direct Radiology Group – 2024- 2025 (*action item*)

   As per the approved Physician Credentialing and Privileging Agreement, and as outlined by the Joint Commission and the Medicare Conditions of Participation, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon Direct Radiology's credentialing and privileging decisions.

   1. Sandeep N. Amesur, MD *(Diagnostic Radiology)*
   2. John R. Anderson, DO *(Diagnostic Radiology)*
   3. Asif Anwar, MD *(Diagnostic Radiology)*
   4. David K. Bass, MD *(Diagnostic Radiology)*
   5. Troy A. Belle, MD *(Diagnostic Radiology)*
   6. Robert Berger, MD *(Diagnostic Radiology)*
   7. Michael D. Berven, MD *(Diagnostic Radiology)*
   8. John W. Boardman, MD *(Diagnostic Radiology)*
   9. Charles W. Westin, MD *(Diagnostic Radiology)*
   10. Alexander R. Vogel, MD *(Diagnostic Radiology)*
   11. James Brull, DO *(Diagnostic Radiology)*
   12. Dennis M. Burton, MD *(Diagnostic Radiology)*
   13. Sanford M. Smoot, MD *(Diagnostic Radiology)*

14. Courtney C. Carter, MD *(Diagnostic Radiology)*
15. Lillian W. Cavin, MD *(Diagnostic Radiology)*
16. Kenneth A. Edgar, MD *(Diagnostic Radiology)*
17. Jeffrey W. Grossman, MD *(Diagnostic Radiology)*
18. Mark L. Harshany, MD *(Diagnostic Radiology)*
19. James C. Haug, DO *(Diagnostic Radiology)*
20. Miriam B. Hulkower, MD *(Diagnostic Radiology)*
21. Ellen D. Johnson, MD *(Diagnostic Radiology)*
22. Benjamin R. Park, DO *(Diagnostic Radiology)*
23. William E. Phillips, MD *(Diagnostic Radiology)*
24. Teppe Popovich, MD *(Diagnostic Radiology)*
25. William T. Randazzo, MD *(Diagnostic Radiology)*
26. Avez A. Rizvi, MD *(Diagnostic Radiology)*
27. Faranak Sadri Tafazoli, MD *(Diagnostic Radiology)*
28. Dishant G. Shah, MD *(Diagnostic Radiology)*
29. Shree J. Shah, MD *(Diagnostic Radiology)*
30. Masood A. Siddiqui, DO *(Diagnostic Radiology)*

D. Change in Staff Category (*action item*)
    1. Gregory Gaskin, MD (*emergency medicine*) – change from Active Staff to Courtesy Staff

E. Medical Staff Governance Structure for Fiscal Year 2024-2025 (*information item*)

F. Medical Executive Committee Meeting Report (*information item*)

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 07/11/2024	Last Review Date: No Review Date	Version: 10
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
Title 8, California Code of Regulations, General Industry Safety Orders, Section 5199 (CCR, GSO, Title 8, 5199) requires that employers' procedures for complying with the regulation be documented in writing and made available to all NIHD workforce for review and training.

PLAN:
Northern Inyo Healthcare District (NIHD) will provide a safe and healthy workplace environment by implementing an effective Aerosolized Transmissible Diseases (ATD) Exposure Control Plan. This ATD Exposure plan applies to the control of exposures to ATD's for high-risk workforce that may have a potential to an ATD exposure due to work environment and job tasks. This plan focuses on safe work practices, personal protective equipment (PPE), engineering and administrative controls, and vaccinations of employees.

OVERVIEW:
The goal of the respiratory protection program for Aerosolized Transmissible Disease (ATD) is to eliminate or minimize health care worker (HCW) exposure to any respiratory aerosol transmissible diseases, which are particles of respiratory secretions from the nose or mouth. Some diseases that are transmitted by respiratory aerosols may or may not manifest primarily with respiratory symptoms. Although there are many infectious diseases that may be transmitted by respiratory aerosols, this standard is meant to address diseases that cause significant morbidity and mortality and represent a significant threat to HCWs and to the health of the community. Examples of diseases for Airborne and Droplet are located within the attachments titled: **Section 5199, Appendix A_ Aerosol Transmissible Diseases/Pathogens: Airborne and Droplet**

POLICY:
NIHD will establish, implement, and maintain an effective written ATD Exposure Control Plan as specified by Cal/OSHA's State Standard, Title 8, and Chapter 4. This plan will be followed by all Northern Inyo Healthcare District HCWs and others working within the facility who may be potentially exposed to respiratory aerosol transmissible disease.

AEROSOLIZED TRANSMISSIBLE DISEASES EXPOSURE CONTROL PLAN:
The Manager of Infection Prevention/Employee Health will be responsible for administering this plan and maintenance of infection control procedures to control the risk of transmission of ATDs. The Employee Health Nurse and the Infection Preventionist will do this with the collaboration of Maintenance leadership, Nursing leadership, Environmental Services Manager, Manager of Cardiopulmonary, Director of Diagnostic Services and Safety. The plan will be reviewed annually or when revised by the program administrator, and by

workforce in their respective work areas. The changes and review will be documented. The Medical Laboratory Director will review annually the Biosafety Plan and potential Aerosolized Transmissible Disease organisms.

EXPOSURE RISK PERSONNEL THAT REQUIRE FIT TESTING - Annually

Nursing Department (RNs, LVNs, CNAs, Medical Office Assistants) Case Managers, House Supervisors- RNs	Rehabilitation Department
Environmental Services/Talent Pool	Cardiopulmonary/EKG/ECHO
Providers: • Emergency Department • Anesthesiologists • Surgeons • Pediatricians • Hospitalists • Same Day Clinic Providers	Radiology Department except Radiologists
Laboratory Clinical Staff	Social Services
Maintenance/Plant Operations	Students (if there is potential for patient contact with airborne isolation patients)

EXPOSURE RISK PERSONNEL THAT REQUIRE FIT TESTING – Every Two Years. NIHD workforce member can elect to be fit tested annually.

Patient Access, and Insurance Verifier	Individuals providing interpreting services in patient care areas
Dieticians & Diet Clerks	Health Information Management (Medical Records)
Pharmacy	Director of Facilities
Security	Radiologists and Clinic Providers except Same Day Clinic (see annual)

FIT Test (N95 mask/PAPR) COMPLIANCE:

- Fit testing will be completed upon hire, and annually, or every two years based on exposure risk.
- Additional fit testing: If workforce member reports, or the employer, physician or other licensed healthcare professional, supervisor, or program administrator makes visual observations of changes in the workforce members physical condition that could affect respirator fit. Such conditions include, but are not limited to, facial scarring, facial hair, dental changes, cosmetic surgery, or a significant change in body weight.
- If, after passing a fit test, the workforce member subsequently notifies the employer, program administrator, supervisor, or physician or other licensed healthcare professional that the fit of the respirator is unacceptable, the workforce member shall be given a reasonable opportunity to select a different respirator face piece and to be retested.
- Annual fit testing will be completed during the department's scheduled time. Note: The new or transferring workforce member will be re-fit tested during their assigned time; example ICU nurse is hired or transferred in January he/she will be fit tested upon hire and re-fit tested again in April.
- Failure to be fit tested by the last day of your departments assigned time will result in the inability to work the first day of the following assigned time until you have been fit tested.

- Workforce members that are on leave of absence or vacation during the scheduled time of their department fit testing **must** be completed within **five days** of their return to work.
- Notification of annual department fit testing will occur a month prior via email.

DEFINITIONS: See Attachments

HIGH HAZARD PROCEDURES:
On patients suspected or known to be infected with an illness or pathogen requiring Airborne Precautions, the following procedures are considered high hazard procedures for risk of exposure to Aerosolized Transmissible Disease, requiring the placement of the patient in an AIIR room if possible, and must use Personal Protective Equipment (PPE) during the procedure. At minimum an N-95 mask or Purified Air Powered Respirator (PAPR) and eye protection is indicated. Staff is expected to follow recommendations for additional PPE as indicated for specific disease processes under transmission-based precautions this list includes, but is not limited to:

1. Sputum Induction~~/collection~~
2. Open suctioning of airways
3. Endotracheal intubation and extubation
4. Tracheostomy procedures (insertion or removal)
5. Bronchoscopy
6. Aerosolized administration of medications when patient is in Airborne Isolation. It is at the discretion of the workforce member to wear N95 if patient on droplet precautions and receiving aerosolized medications.
7. Laboratory procedures that may aerosolize pathogens refer to Laboratory Biosafety Plan
8. Obtaining a nasal swab or throat culture with person known or suspected airborne disease.

Note:
Bronchoscopy and other similar high hazard procedures will be done in an Airborne Infection Isolation Room (AIIR). .
Lesser procedures, like obtaining a nasal swab will be done with ~~a~~ minimally a surgical mask or N-95 mask if atypical respiratory illness such as novel avian flu is suspected, face shield, gloves must be worn. A gown is donned if patient unable has poor respiratory etiquette and/or poor hand hygiene. Persons not performing the procedures are to be excluded from the area.
Exception: Where no AIIR or area is available and the treating physician determines that it would be detrimental to the patient's condition to delay performing the procedure, high hazard procedures may be conducted in other areas. In that case, workforce members working in the room or area where the procedure is performed shall use respiratory protection and shall use all necessary personal protective equipment**.**
NOTE: NIHD has PAPRs available - see policy for use and maintenance.

NIHD WORK FORCE IMMUNIZATIONS:
NIHD will comply with the "Mandatory Vaccination Recommendations for Susceptible Health Care Workers" as listed in Appendix E below of the Cal/OSHA ATD Standard.
Employee Health, during the pre-employment physical process, obtains titers for the illnesses listed below- if the prospective workforce member does not have documented proof of the vaccinations. Vaccinations are provided free of charge when indicated. Employee Health will also provide current Health Care Workers titers and vaccines to meet current standards declinations must be signed by the HCW in lieu of the vaccination after education on the vaccine and NIHD's commitment to safety for the patients, the HCW, and his or her family.

Appendix: Aerosol Transmissible Disease Vaccination Recommendations for Susceptible Health Care Workers (Mandatory)

Vaccine	Schedule	Titer
Influenza	One dose annually	No
Measles	Two doses	Or immunity via titer
Mumps	Two doses	Or immunity via titer
Rubella	One dose	Or immunity via titer
Tetanus, Diphtheria, and Acellular Pertussis (Tdap)	One dose, booster as recommended	No
Varicella-zoster (VZV)	Two doses	Or immunity via tier or documentation of history

Source: California Department of Public Health, Immunization Branch. Immunity should be determined in consultation with https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf for current year.

WORK PRACTICE CONTROLS:

SOURCE CONTROL MEASURES: Measures to prevent patients, staff, or visitors from spreading illness inside of the hospital.

On Arrival to the Hospital:

1. Hand hygiene stations and Respiratory Hygiene/Cough Etiquette are at every entrance to the hospital with signs encouraging their use.
2. If indicated, warning/education signs may also be placed at entrances explaining any special concerns or limitations regarding entrance to the hospital e.g. with outbreak of influenza.
3. Patients, visitors, and caregivers will be instructed on Respiratory Hygiene/ Cough Etiquette measures by the hospital staff, with easy access to all the necessary sanitation supplies.
    a. Cover mouth and nose for coughs and sneezes with Kleenex, linen, or elbow.
    b. To use the available surgical masks as soon as possible if actively coughing.
    c. To perform hand hygiene frequently and after handling their secretions.
    d. To dispose of contaminated tissues, napkins, linens into “no-touch” receptacles.
4. Entry may be denied to visitors if they already know they have suspected or confirmed influenza, another known serious respiratory illness, tuberculosis, and/or possibly others on a case by case basis except in regards to Emergency Medical Treatment and Labor Act (EMTALA) related to pregnancy or emergency care.
5. Elective procedures may also be postponed for patients with suspected or confirmed influenza or another known serious respiratory illness until they are no longer infectious.
6. NIHD prohibits misters for human comfort (e.g. patio misters) anywhere on the campus this includes employee break areas.

On arrival to the Emergency Department (ED) Area:

1. Same entry procedures as above. Hand hygiene station is at the Emergency Department entrance.

2. The Emergency Department personnel will have the patients mask immediately if the complaint is an Influenza-like-Illness (ILI) or cough, or suspected airborne disease.
3. A separate waiting room was developed so that those with ILI and potential airborne disease can potentially be segregated from those without.
4. Respiratory like illness patients are isolated to an Emergency Department single room or kept masked and physically located $\geq$ 6 feet from other patients. Friends and family are instructed in the use of surgical masks and any other necessary PPE being used. They are encouraged to follow instructions and to ask for clarification, so that they have the understanding of why the isolation procedures are used.
5. Person with suspected or confirmed airborne disease will be placed in private room with door closed. Staff entering room will don a N95 mask or PAPR
6. Appropriate isolation signage will be posted outside the room visible to hospital staff and visitors

On Arrival to another Hospital Unit:

1. Same entry procedures as above with access to hand hygiene stations and necessary sanitation supplies.
2. House Supervisor will report any airborne-suspected patients via the House Supervisor end of shift 12-hour report.
3. Severe Acute Respiratory Syndrome has its own assessment/screening form that is found on the hospital Intranet.
4. Source patients from any department, including the Emergency Department, are put into single rooms when available and the door is closed. Airborne precautions will be initiated, when appropriate. Visitors are instructed in the use of PPE and restricted to those most crucial to the patient's well-being.

Room Placement:

Airborne infection isolation rooms units will be used for patients who are suspected of having airborne transmissible disease, e.g. TB, SARS, Smallpox, Avian Flu, and Pneumonic Plague.
Airborne isolation rooms are private rooms that have monitored negative air pressure in relation to the exterior surrounding areas, so that air does not come out from under the door because the pressure outside the door is > than inside the room. See the section under *Engineering Controls* related to Air Exchanges per hour and other specifics. Our current best options for any patient include:

- Option 1: Room 5 on the Acute/Subacute and ICU RM 1
- Option 2: If no Airborne Infection Isolation Room available put patient in surgical mask, keep door closed, staff and visitors to wear a N95 or PAPR.
- For the RHC and Pediatric clinic negative pressure room.

Source Patient Control:

1. The patient will remain in the room, unless transport is necessary for a diagnostic procedure. The patient will be kept masked with a surgical mask and the transport team will wear a fit-tested N-95 mask.
2. Information about patients who have or may have an ATD is shared with appropriate personnel before transferring or transporting the patient to other departments or other facilities using SBAR, or Ticket to Ride, transfer form or Handoff report.
3. Personal Protective Equipment and Isolation Precautions implemented by staff may be discontinued based on documented, negative laboratory studies. This should be decided with input from any one or more of the following: Infection Preventionist or designee, Infection Control Medical Staff Chairperson, the unit's Nursing leadership and the patient's physician, Inyo County Health Officer, or California State Health Department official.
4. Visitors should be limited to only family or friends crucial to the patient's well-being.

5. Patient care equipment:
    a. Equipment (e.g. designated computer, vital sign equipment, stethoscopes, and commodes) should be kept in the patient's room. Use disposable equipment as much as possible.
    b. Any reusable equipment has to be cleaned per hospital protocol before re-use.
6. Linens, waste, and room cleaning as per policy.

Precautions Required for SARS, Avian, And Other Serious Airborne Illnesses:

1. Standard
2. Airborne and Droplet
3. Contact

PPE Required When Entering an Airborne Isolation Room:

1. Fit-tested N-95 Mask or PAPR
2. Face shields or Eye Protectors
3. Disposable Gowns: For substantial contact with the patient or environmental surfaces.
4. Gloves

Reporting the Illness:

NIHD will follow federal, state, local guidelines for reporting airborne diseases. The Confidential Morbidity Report form is on the NIHD Intranet. The back of the form tells you by which method and how quickly to report each reportable illness. For example, with SARS you are to call Inyo County Health Department immediately.

Procedure If NIHD Has Insufficient Isolation Rooms:

If the patient needs an airborne isolation room and there is not one available, the patient should be a transfer to another facility in a timely manner.

1. Transfers to other facilities: Transfer should occur within **5** hours of identification, unless the initial encounter with patient occurs between 3:30pm and 7:00 am, in which case the patient must be transferred by 11:00 am. If the provider contacts the local health officer and determines that no facility is available to provide Airborne Infection Isolation (AII), then the patient may remain at NIHD, the provider must continue to contact the local health officer and other facilities every 24 hours to attempt the transfer, and at least every 24 hours thereafter, one of the following:
    a. There is no room or area available within that jurisdiction.
    b. Reasonable efforts have been made to contact establishments outside of that jurisdiction.
    c. Applicable measures recommended by the local health officer and the Physician or other licensed health care professional
    d. Patients exhibiting flu like symptoms during flu season or suspected or confirmed COVID-19 do not require referral and transfer.

Exception to above:

1. The patient need not be transferred if the treating physician determines that the transfer would be detrimental to the patient's condition. In that case, the HCW will use all necessary respiratory protection when entering the patient's room. The patient's condition has to be reviewed at least every 24 hours. Once transfer is safe, then it should still occur in the timeframe above.

2. Where it is not feasible to provide Airborne Infection isolation rooms or areas to individuals suspected or confirmed to be infected with or carriers of novel (ex: Flu, COVID-19) or unknown ATPs, the employer shall provide other effective control measures to reduce the risk of transmission to HCWs, which shall include the use of respiratory protection in accordance with subsection (g) and Section 5144, Respiratory Protection of these orders.

HCW Control Measures:

1. Keeping personnel at home while they are ill to reduce the risk of spreading influenza or other airborne illnesses is essential
2. HCW TB screening every two years and l TB symptom questionnaire records will be kept in Employee Health. HCW's identified to have latent TB will complete annual questionnaire.
3. Continuing monitoring of hand hygiene and PPE compliance.
4. Continue the yearly influenza vaccination policy, and required vaccines. (Covered under Vaccination Section)
5. Monitor any HCW with an airborne exposure. (Covered under Exposure Evaluation Section)
6. Annual education on Aerosolized Transmissible Disease for HCW that have exposure risk.
7. HCW's are instructed on respiratory illness symptoms and how to report.
8. HCW's who exhibit COVID-19 symptoms and are on a Return to Work or Exposure Pathway will be offered testing at no cost.

PATIENT SCREENING: Patients will be screened during the triage period in the Emergency Department during the admission assessment for inpatients, as appropriate, to evaluate for any symptoms of Aerosolized Transmissible Disease infections. Any persons entering the District will have passive screening for respiratory illnesses.

1. For **tuberculosis** this would include:
   a. Cough for more than 3 weeks not explained by non-infectious conditions
   b. Hemoptysis
   c. Unexplained significant weight loss
   d. Fatigue
   e. Night sweats
   f. Known exposure to a TB patient
   g. Temporary or permanent residence of ≥1 month in a country with a high TB rate

2. For Respiratory illnesses (COVID-19, FLU, RSV) signs and symptoms would include:
   a. Fever > 100 F with cough and/or sore throat and headache;
   b. Body aches, nasal congestion or discharge, chills and fatigue;
   c. Nausea, vomiting, diarrhea or other GI symptoms may also be present

3. Patient statement that they have an aerosol or droplet transmissible respiratory disease.

CLEANING AND DISINFECTION:

1. Routine cleaning and disinfection strategies used during influenza season can be applied to the environmental management of Influenza
2. Dedicated disposable equipment is to be used whenever possible.

3. Non-disposable equipment is to be cleaned and disinfected according to established agency policies - "Infectious and Noninfectious Waste Disposal Procedure."
4. Management of laundry, utensils, and medical waste should also be performed in accordance with procedures followed for seasonal influenza.

PERSONAL PROTECTIVE EQUIPMENT/RESPIRATORY PROTECTION

1. Adherence to Standard Precautions and Transmission Based Precautions, as appropriate for the patient's disease status, is mandatory for all NIHD workforce and departments.
2. Droplet Precautions: Permit the use of surgical masks rather than respiratory protection, i.e., use of respirators. Recognizing that surgical masks do not provide protection against inhalation of airborne infectious aerosols, NIHD allows health care personnel to use N-95 masks should they prefer that level of protection.
3. Clinical staff who are assigned to patients with suspected or confirmed infectious Pulmonary TB, or other aerosol transmissible diseases requiring use of respirator will be provided and fitted with a National Institute for Occupational Safety and Health approved (at least N95) Respirator Mask for individual, personal protection prior to providing care. Trained personnel will instruct the clinical staff members on proper respirator use and fit-check, in accordance with the manufacturer's instructions and guidelines.
    a. Every attempt will be made to have an adequate supply of all types of N-95 masks we currently use for fit tests.
    b. The standard is to use a mask if needed and discard it after use. They should be discarded after each patient encounter. EXCEPTION: When caring for airborne patients without mixing and during times of shortage NIHD will follow regulatory guidelines for extended and re-use of masks.
    c. The Purchasing Department is responsible for monitoring mask numbers and will work in conjunction with the Infection Preventionist to ensure mask availability.
4. Clinical staff that cannot be adequately fitted with the National Institute for Occupational Safety and Health approved respirators will not be assigned to these patients, unless they have been trained to use the PAPR and a PAPR is available.
5. Personnel with histories of respiratory problems/compromise or those with known lack of immunity to the organism (e.g.: chickenpox) should not be assigned to these patients.
6. Unprotected HCW's should be prevented from entering areas where aerosol generation procedures were performed until the required clearance time has elapsed.
7. When respirators are necessary to protect the HCW from other hazards, including the uncontrolled release of microbiological spores or exposure to chemical or radiologic agents, respirator selection shall be made in accordance with the anticipated risk.
8. In summary, NIHD provides, and ensures that HCW's use, a fit-tested N-95 respirator or PAPR when::
    a. Enters an Airborne infection isolation room or area or an Airborne infection isolation area in use for Airborne Infection Isolation;
    b. Present during the performance of procedures or services for an Airborne infectious disease case or suspected case;
    c. Takes part in aerosol generating procedures on patient suspected or known to be infected with an illness or pathogen requiring airborne precautions such as sputum induction, bronchoscopy, open suctioning, CPR, intubation or extubation, Pulmonary function testing, collection of nasal pharyngeal lab specimens.
    d. Repairs, replaces, or maintains air systems or equipment that may contain or generate aerosolized pathogens;
    e. Is working in an area occupied by an airborne infectious disease case or suspected case, during decontamination procedures after the person has left the area and as required.

f. Is performing a task for which the Biosafety Plan or Exposure Control Plan requires the use of respirators; or
g. Transports an Airborne infectious disease case or suspected case within the facility or in an enclosed vehicle (e.g., van, car, ambulance or Air transport when the patient is not masked.

9. Medical Evaluation for Fit Testing:
    a. HCWs that meet fit testing requirements must complete OSHA Respirator Medical Evaluation Questionnaire upon hire and if there are any medical changes. This is done to determine the ability to use a respirator before the HCW is fit tested or required to use the respirator. This form is the OSHA approved form for respirator fit testing.
    b. The questionnaire is provided during the HCW physical and or to the contracted service and sent to Employee Health.
    c. The record is stored in the HCW confidential employee health records.
    d. After the medical evaluation, the HCW can have the fit test scheduled.

10. Fit Testing: "*N95 Mask Fit Testing Using the Portacount Pro Policy*"
    a. The fit tests are performed on the same size, make, model and style of respirator, as the HCW will use. When fit testing single use respirators, a new respirator shall be used for each HCW.
    b. The employer shall ensure that each HCW who is assigned to use a filtering face piece or other tight-fitting respirator passes a fit test:
        1. At the time of initial fitting;
        2. When a different size, make, model or style of respirator is used; and
        3. At least annually or biannual thereafter per exposure risk (see table above).
    c. NIHD requires an additional fit test when the HCW reports, or the employer, physician or other licensed health care professional, supervisor, or program administrator makes visual observations of changes in the HCWs physical condition that could affect respirator fit. Such conditions include, but are not limited to, facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight.
    d. If, after passing a fit test, the HCW subsequently notifies the employer, program administrator, supervisor, or Physician or other licensed health care professional that the fit of the respirator is unacceptable, the HCW shall be given a reasonable opportunity to select a different respirator face piece and to be retested.
    e. NIHD will ensure that each respirator user is provided with initial and annual training with one or more of the below options:
        - During annual fit testing
        - Hands-on

11. Hands-on training will be provided for persons using a PAPR.
12. Qualitative Fit test will be performed, in place of the quantitative fit test, in an emergency situation when N95 mask supply is in short supply. If Porta Count machine unavailable.

MEDICAL SERVICES

1. NIHD provides any employee with *occupational exposure* medical services for tuberculosis and other ATDs, and infection with Aerosol transmissible pathogen and Aerosol transmissible pathogen -- laboratory, in accordance with applicable public health guidelines, for the type of work setting and disease. Contracted staff will be followed in the Emergency Department under their workman's compensation. NIHD also acts as the evaluating health care professional through our Emergency Department. Following an exposure incident, the HCW may request follow-up medical care from another health care provider. When this occurs, NIHD will ensure that the HCW is aware of a medical follow-up is arranged from a Physician or other licensed health care professional other than through our Emergency Department.

2. Medical services, including vaccinations, tests, examinations, evaluations, determinations, procedures, and medical management and follow-up, shall be:
    a. Performed by or under the supervision of the Emergency Room Physician or designee.
    b. Employee Health Department
    c. Provided according to applicable public health guidelines; and
    d. Provided in a manner that ensure the confidentiality of HCW and patients. Test results and other information regarding exposure incidents and TB conversions shall be provided without providing the name of the source individual.
3. If workforce member has a conversion, he/she will follow-up with a care provider. All diagnostic tests and questionnaires will be documented in Employee Health chart.

EXPOSURE EVALUATION AND FOLLOW-UP

1. A health care provider or the employer of a health care provider who determines that a HCW, patient or visitor, is a reportable aerosol transmissible disease case or suspected case shall report, or ensure that the health care provider reports, the case to the local health officer, in accordance with Title 17, with the exception of COVID-19.
2. Any healthcare worker who has unprotected direct contact with an airborne illness must report the exposure to Employee Health, or Infection Prevention team as soon as possible, either directly or with the assistance of the unit director/manager or House supervisor. The Employee Health Nurse, Infection Preventionist, will complete an investigation and determine risk and follow-up recommendations. It is critical to report exposures immediately when the source is a known life-threatening illness, such as, COVID-19 SARS, Avian flu, Smallpox, etc.
3. An Exposure Incident: Significant exposure- exposure to a source of Aerosolized Transmissible Pathogens in which the circumstances make disease transmission sufficiently likely that the HCW requires further evaluation by a physician or other physician or other licensed health care provider. The likelihood of transmission is determined by:
    a. Exposure scenario including distance, time, PPE used
    b. Specific pathogen
    c. Infectivity of the source
    d. Susceptibility of the host (vaccination status is one component)-
    e. Refer for a medical evaluation if the susceptibility is unknown.
4. In addition to the report required, NIHD's Infection Preventionist and/or Employee Health team shall, to the extent that the information is available:
    a. Staff member to complete Unusual Occurrence Report (UOR)
    b. Decide what the affected HCW needs to receive effective medical intervention to prevent disease or mitigate the disease course.
    c. Instruct the HCW to monitor for disease symptoms for the duration determined by CDC.
    d. If a cough or fever develops; the HCW should seek medical evaluation immediately and notify the Infection Control nurse.
    e. Assess whether other agencies may be affected. There is an Aerosolized Transmissible Disease notification form to be filled out in the Emergency Department to help track HCW's who may have been exposed.
    f. Initiate a prompt investigation to identify exposed employees. Title 17 and other regulatory requirements determine notification to federal, state and local authorities. The notification shall include the date, time, and nature of the potential exposure, and provide any other information that is necessary for the other employer(s) to evaluate the potential exposure of his or her employees. The notifying NIHD provider or Infection Preventionist shall not reveal the identity of the source patient to the other employers unless the patient or employee consents to the disclosure.

- *NOTE 1: These potentially exposed HCW's may include, but are not limited to, paramedics, emergency medical technicians, emergency responders, home health care personnel, homeless shelter personnel, personnel at referring health care facilities or agencies, and corrections personnel.*
- *NOTE 2: Some diseases, such as meningococcal disease, require prompt prophylaxis of exposed individuals to prevent disease. Some diseases, such as varicella, have a limited window in which to administer vaccine to non-immune contacts. Exposure to some diseases may create a need to temporarily remove an HCW from certain duties during a potential period of communicability as determined by the local health officer for that jurisdiction of the potentially exposed HCW.. For other diseases such as tuberculosis there may not be a need for immediate medical intervention, however prompt follow up is important to the success of identifying exposed HCWs.*

5. When NIHD becomes aware that HCWs may have been exposed to a reportable aerosol transmissible disease case or suspected case, or to an exposure incident involving an Aerosol transmissible pathogen this includes outbreak investigation–shall do the following:
   a. Within a timeframe that is reasonable for the specific disease, but in no case later than 72 hours following, as applicable, conduct an analysis of the exposure scenario to determine which HCWs had significant exposures. This analysis shall be conducted by the Infection Preventionist with assistance from Inyo County Health Department when indicated. This analysis will include the HCWs names and shall also record the basis for any determination that an HCW need not be included in post-exposure follow-up because the HCW did not have a significant exposure or because Employee Health, Infection Prevention, Physician, or other licensed health care professional determined that the HCW is immune to the infection in accordance with applicable public health guidelines. The exposure analysis shall be made available to the local health officer upon request. The name of the person making the determination, and the identity of any Physician or other licensed health care professional or local health officer consulted in making the determination shall be recorded.
   b. Within a timeframe that is reasonable for the specific disease, but in no case later than 96 hours of becoming aware of the potential exposure, notify HCWs who had significant exposures of the date, time, and nature of the exposure.
   c. Provide post-exposure medical evaluation to HCWs who had a significant high-risk exposure as soon as feasible if HCW requests. The evaluation shall be conducted by a physician or other licensed health care professional knowledgeable about the specific disease, including appropriate vaccination, prophylaxis and treatment. For *M. tuberculosis*, and for other pathogens where recommended by applicable public health guidelines, this shall include testing of the isolate from the source individual or material for drug susceptibility, unless that it is not feasible.
6. Have employee contact Human Resources and contracted HCW must notify their agency if employee is not allowed to work based on risk exposure. Information provided to the physician or other licensed health care professional.
   a. NIHD will ensure that all physicians or other licensed health care professional responsible for making determinations and performing procedures as part of the medical services program are provided a copy of this standard and applicable public health guideline. For respirator medical evaluations, the employer shall provide information regarding the type of respiratory protection used, a description of the work effort required, any special environmental conditions that exist (e.g., heat, confined space entry), additional requirements for protective clothing and equipment, and the duration and frequency of respirator use.
   b. Each employer shall ensure that the Emergency Department physician or a physician or other licensed health care professional who evaluates an HCW after an exposure except for COVID-19 incident is provided the following information:
      i. A description of the exposed employee's duties as they relate to the exposure incident;
      ii. The circumstances under which the exposure incident occurred;

iii. Any available diagnostic test results, including drug susceptibility pattern or other information relating to the source of exposure that could assist in the medical management.
iv. All of the HCW's medical records for the employee that are relevant to the management, including tuberculin skin test results and other relevant tests for ATP infections, vaccination status, and determinations of immunity.

Note: Healthcare workers who are positive or exposed to COVID-19 are to notify Employee Health or Infection Prevention for Return to Work or Testing Pathway. If an NIHD workforce member is exposed in the workplace and becomes ill, the HCW may seek treatment in the Emergency Department, Primary Care Provider, or RHC Same Day Clinic.

7. Precautionary removal recommendation from the emergency room physician, other physician or other licensed health care professional Inyo County Health Department, Infection Prevention or Chief Medical Officer.
   a. NIHD, when necessary, may request from the above an opinion regarding whether precautionary removal from the HCW's regular assignment is necessary to prevent spread of the disease agent and what type of alternate work assignment may be provided. This recommendation will be documented in writing and provided to Human Resources and to the employee.
   b. Where precautionary removal is recommended, NIHD shall maintain until the NIHD employee is determined to be noninfectious, the NIHD employee's earnings, seniority, and all other employee rights and benefits, including the employee's right to his or her former job status, as if the employee had not been removed from his or her job or otherwise medically limited.

   EXCEPTION: Precautionary removal provisions do not extend to any period of time during which the employee is unable to work for reasons other than precautionary removal.

8. Written opinion from the physician or other licensed health care professional related to precautionary removal from work
   a. For TB conversions with active TB and all reportable aerosol transmissible disease and aerosol transmissible pathogen – laboratory exposure incidents, the written opinion shall be limited to the following information:
      i. The HCWs TB test status or applicable reportable aerosol transmissible disease test status for the exposure of concern;
      ii. Latent TB conversions will be reported to Inyo County Health Department and employee is encouraged to follow-up with provider.
      i. Infectious status;
      ii. A statement that the HCW has been informed of the results of the medical evaluation and has been offered any applicable, testing, vaccinations, prophylaxis, or treatment;
      iii. A statement that the HCW has been told about any medical conditions resulting from exposure to TB, other reportable aerosol transmissible disease, or aerosol transmissible pathogen – laboratory that require further evaluation or treatment and that the HCW has been informed of treatment options; and
      iv. Any recommendations for precautionary removal from the employee's regular assignment with the guidance of Human Resources.

All other findings or diagnoses shall remain confidential and shall not be included in the written report.

TRAINING:

1. NIHD will provide training to NIHD workforce with occupational exposure, and they will participate in the training program as listed in the exposure risk personnel that require fit testing tables. The Aerosolized Transmissible Disease training or notification of changes will occur as stated below:
   a. At the time of initial assignment to tasks where occupational exposure may take place;
   b. At upon hire, and least annually thereafter, not to exceed 12 months from the previous training;

c. For NIHD workforce who have received training on aerosol transmissible diseases in the year preceding the effective date of the standard, only training with respect to the provisions of the standard that were not included previously need to be provided.
d. When changes, such as introduction of new engineering or work practice controls, modification of tasks or procedures or institution of new tasks or procedures, affect the HCW's occupational exposure or control measures. The additional training may be limited to addressing the new exposures or control measures.

2. Training material appropriate in content and vocabulary to the educational level, literacy, and language of HCW shall be used.
3. The training program shall contain at a minimum the following elements:
    a. An accessible copy of the regulatory text of this standard and an explanation of its contents.
    b. A general explanation of Aerosolized Transmissible Diseases including the signs and symptoms of that require further medical evaluation.
    c. An explanation of the modes of transmission of Aerosol transmissible pathogen – or Aerosol transmissible pathogen – laboratory and applicable source control procedures.
    d. An explanation of the employer's ATD Exposure Control Plan and/or Respiratory Protection Program and Biosafety Plan, and the means by which the HCW can obtain a copy of the written plan and how they can provide input as to its effectiveness.
    e. An explanation of the appropriate methods for recognizing tasks and other activities that may expose the HCW to Aerosol transmissible pathogen or Aerosol transmissible pathogen – laboratory
    f. An explanation of the use and limitations of methods that will prevent or reduce exposure to Aerosol transmissible pathogen or Aerosol transmissible pathogen laboratory including appropriate engineering and work practice controls, decontamination and disinfection procedures, and personal and respiratory protective equipment.
    g. An explanation of the basis for selection of personal protective equipment, its uses and limitations, and the types, proper use, location, removal, handling, cleaning, decontamination and disposal of the items of personal protective equipment HCW will use.
    h. A description of the employer's TB surveillance procedures, including the information that persons who are immune-compromised may have a false negative test for Latent TB infection
    i. Training meeting the annual requirements for NIHD workforce whose assignment includes the use of a respirator (N95,PAPR).
    j. Information on the vaccines made available by Employee Health, including information on their efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.
    k. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident, the medical follow-up that will be made available, and post-exposure evaluation.
    l. Information on the employer's surge plan as it pertains to the duties that the HCW will perform. As applicable, this training shall cover the plan for surge receiving and treatment of patients, patient isolation procedures, surge procedures for handling of specimens, including specimens from persons who may have been contaminated as the result of a release of a biological agent, how to access supplies needed for the response including personal protective equipment and respirators, decontamination facilities and procedures, and how to coordinate with emergency response personnel from other agencies.

ENGINEERING CONTROLS

1. Specific requirements for Airborne Infection Isolation Rooms and areas. Hospital isolation rooms constructed in conformance with General Requirements of Mechanical Ventilation Systems.

2. Negative pressure shall be maintained in Airborne Infection Isolation Rooms or areas. The ventilation rate shall be 12 or more air changes per hour (ACH). The required ventilation rate may be achieved in part by using in-room high efficiency particulate air (HEPA) filtration or other air cleaning technologies, but in no case shall the outdoor air supply ventilation rate be less than six ACH. Hoods, booths, tents and other local exhaust control measures shall comply with Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings.
3. Engineering controls shall be maintained, inspected and performance monitored for exhaust or recirculation filter loading and leakage at least annually, whenever filters are changed, and more often if necessary to maintain effectiveness. NIHD's maintenance department does check at least quarterly. NIHD Plant Maintenance has an aggressive filter-checking program that is managed with a software program for this purpose. If a problem(s) prevent the room from providing effective AII, then the room shall not be used for that purpose until the condition is corrected.
4. Ventilation systems for AII rooms or areas shall be constructed, installed, inspected, operated, tested, and maintained in accordance with regulatory guidelines General Requirements of Mechanical Ventilation Systems, of these orders. Inspections, testing and maintenance shall be documented in writing.
5. Air from Airborne Infection Isolation Rooms (AIIR) or areas, and areas that are connected via plenums or other shared air spaces shall be exhausted directly outside, away from intake vents, HCWs, and the general public. Air that cannot be exhausted in such a manner or that must be recirculated must pass through HEPA filters before discharge or recirculation.
6. Ducts carrying air that may reasonably be anticipated to contain aerosolized *M. tuberculosis* or other airborne infectious pathogen shall be maintained under negative pressure for their entire length before in-duct HEPA filtration or until the ducts exit the building for discharge.
7. Doors and windows of Airborne Infection Isolation Rooms or areas shall be kept closed while in use for airborne infection isolation, except when doors are opened for entering or exiting.
8. When a case or suspected case vacates an Airborne Infection Isolation Rooms or area, the room or area shall be ventilated according to Table 1 in the Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings for a removal efficiency of 99.9 % before permitting HCW to enter without respiratory protection.

TABLE 1 Air Exchange Within NIHD Departments:

Department Name	Air exchange per Hour (ACH)	Minutes Required for Removal efficiency †	
		99%	99.9%
Emergency Department	6 ACH	46	69
Emergency Department Triage	12 ACH	23	35
Med-Surg Non AIIR	6 ACH	46	69
ICU Non AIIR	6 ACH	46	69
AIIR M/S 5 & ICU 1	12 ACH	23	35
OB	6 ACH	46	69
Pre-op/PACU	6 ACH	46	69
OR	25 ACH	14	21
Outpatient Infusion	6 ACH	46	69
Clinics	2 ACH	138	207
Negative Pressure Room in Pediatric Clinic and RHC	50 ACH	6	8

* This table can be used to estimate the time necessary to clear the air of airborne *Mycobacterium tuberculosis* after the source patient leaves the area or when aerosol-producing procedures are complete.
† Time in minutes to reduce the airborne concentration by 99% or 99.9%.

LABORATORIES

1. The biological safety officer at NIHD is the Medical Director of Laboratory Services.
2. The biological safety officer performs a risk assessment in accordance with accepted methodology for each agent and procedure involving the handling of aerosolized transmissible disease pathogens in the lab Aerosol transmissible pathogen laboratory
3. Our laboratory has feasible engineering and work practice controls, in accordance with the risk assessment to minimize the HCW exposures to Aerosol transmissible pathogen – laboratory. If exposure still remains after the institution of engineering and work practice controls, then the HCW will use the appropriate PPE when and where necessary.
4. Biosafety Plan: The employer shall establish, implement, and maintain an effective written Biosafety Plan to minimize exposures to Aerosol transmissible pathogen – laboratory that may be transmitted by laboratory aerosols. The Biosafety Plan is kept in the laboratory's safety manual and includes the following:
    a. Identifies a biological safety officer(s) with the necessary knowledge, authority and responsibility for implementing the Biosafety Plan
    b. Establishes safe handling procedures and prohibit practices, such as sniffing *in vitro* cultures that may increase exposure to infectious agents.
    c. Identifies any operations or conditions in which respiratory protection will be required.
    d. Establishes emergency procedures for uncontrolled releases within the laboratory facility and untreated releases outside the laboratory facility. These procedures shall include effective means of reporting such incidents to the local health officer.
    e. Includes procedures for communication of hazards and NIHD workforce training. This shall include training in the Biosafety Plan and emergency procedures.
    f. Includes an effective procedure for obtaining the active involvement of HCW in reviewing and updating the Biosafety Plan with respect to the procedures performed in their respective work areas or departments on an annual (or more frequent) basis.
    g. Includes procedures for the biological safety officer(s) to review plans for facility design and construction that will affect the control measures for Aerosol transmissible pathogen – laboratory.
    h. Includes procedures for inspection of laboratory facilities, including an audit of Biosafety procedures. These inspections shall be performed at least annually. Hazards found during the inspection, and actions taken to correct hazards, shall be recorded.
5. Recordkeeping will be done by the biological safety officer.

SURGE PROCEDURES

1. In the event of a surge of patients due to infectious disease, NIHD staff will follow established policies for Disaster Preparedness.
2. NIHD may participate in a multi-agency management plan, and will be directed by the Incident Command System and the county Emergency Operations Center.
3. Respiratory and personal protective equipment may be stockpiled and distributed by the Inyo County Health Department for use during a public health surge.

RECORDKEEPING

1. Medical records.

a. Employers are responsible for recording cases of Aerosolized Transmissible Diseases for occupational exposures, and if it involves days away from work and/or medical treatment. This record may not be combined with non-medical personnel records.
b. This record shall include:
    i. The HCW name and any other identifier used in the workplace;
    ii. The HCW vaccination status for all vaccines required by this standard, including the information provided by Employee Health, any vaccine record provided by the employee HCW, and any signed declination forms;

    EXCEPTION: As to seasonal influenza vaccine, the medical record need only contain a declination form for the most recent seasonal influenza vaccine.
    iii. A copy of all written opinions provided by a Physician or other licensed health care professional in accordance with this standard, and the results of all TB assessments; and
    iv. A copy of the information regarding an exposure incident that was provided to the Physician or other licensed health care.
c. Confidentiality. The employer shall ensure that all medical records required by this section are:
    i. Kept confidential; and
    ii. Not disclosed or reported without written consent to any person within or outside the workplace except as permitted by this section or as may be required by law.

    NOTE: These provisions do not apply to records that do not contain individually identifiable medical information, or from which individually identifiable medical information has been removed.
d. The employer shall maintain the medical records required by this section for at least the duration of employment plus 30 years in accordance with Section 3204, Access to Employee Exposure and Medical Records, of these orders.

2. Training records.
    a. Training records shall include the following information:
        i. The date(s) of the training session(s);
        ii. The contents or a summary of the training session(s);
        iii. The names and qualifications of persons conducting the training or who are designated to respond to interactive questions; and
        iv. The names and job titles of all persons attending the training sessions.
    b. Training records shall be maintained for 3 years from the date on which the training occurred.
3. Records of implementation of Aerosolized Transmissible Disease Plan and/or Biosafety Plan.
    a. Records of annual review of the ATD Plan and Respiratory Protection Program Biosafety Plan shall include the name(s) of the person conducting the review, the dates the review was conducted and completed, the name(s) and work area(s) of HCWs involved, and a summary of the conclusions. The record shall be retained for three years.
    b. Records of exposure incidents shall be retained and made available as HCW exposure records in accordance with Section 3204. These records shall include:
        i. The date of the exposure incident;
        ii. The names, and any other identifiers used in the workplace, of employees who were included in the exposure evaluation;
        iii. The disease or pathogen to which HCW may have been exposed;
        iv. The name and job title of the person performing the evaluation;
        v. The identity of any local health officer and/or Physician or other licensed health care consulted;
        vi. The date of the evaluation; and
        vii. The date of contact and contact information for any other employer notified by NIHD regarding potential employee exposure.

c. Records of the unavailability of vaccine shall include the name of the person who determined that the vaccine was not available, the name and affiliation of the person providing the vaccine availability information, and the date of the contact. This record shall be retained for three years.
d. Records of the unavailability of Airborne Infection Isolation Rooms or areas shall include the name of the person who determined that an Airborne Infection Isolation Room or area was not available, the names and the affiliation of persons contacted for transfer possibilities, and the date of the contact, the name and contact information for the local health officer providing assistance, and the times and dates of these contacts. This record, which shall not contain a patient's individually identifiable medical information, shall be retained for three years.
e. Records of decisions not to transfer a patient to another facility for Airborne Infection Isolation Room for medical reasons shall be documented in the patient's chart, and a summary shall be provided to the plan administrator providing only the name of the physician determining that the patient was not able to be transferred, the date and time of the initial decision and the date, time and identity of the person(s) who performed each daily review. The summary record, which shall not contain a patient's individually identifiable medical information, shall be retained for three years.
f. Records of inspection, testing and maintenance of non-disposable engineering controls including ventilation and other air handling systems, air filtration systems, containment equipment, biological safety cabinets, and waste treatment systems shall be maintained for a minimum of five years and shall include the name(s) and affiliation(s) of the person(s) performing the test, inspection or maintenance, the date, and any significant findings and actions that were taken. Plant operation uses a computer-based work system for documentation of records.
g. As stated under 29 CFR 1910.134(m)(2), the following information must be recorded: the name of the HCW ; the type of test performed (QLFT or QNFT); specific respirator tested; date of the test; and the results of the test. This information must be retained until the next fit test is administered.

4. Availability.
   a. The employer shall ensure that all records, other than the HCW medical records more specifically dealt with in this subsection, required to be maintained by this section shall be made available upon request by the exposed subject or regulatory agencies if requested.
   b. NIHD workforce training records, the exposure control plan and/or Biosafety plan, and records of implementation of the Aerosolized Transmissible Disease exposure control plan and Respiratory Protection Program and the Biosafety-plan other than medical records containing individually identifiable medical information, shall be made available in accordance to HCW and/or representatives.
   c. NIHD workforce medical records required by this subsection shall be provided upon request by the exposed HCW or anyone having the written consent of the HCW, the Inyo County Health Officer, and to the Chief and National Institute for Occupational Safety and Health in accordance with section 3204 of these orders, Access to HCW exposure and medical records, for examination and copying.
5. Transfer of Records.
   a. NIHD will comply with the requirements involving the transfer of NIHD workforce medical and exposure records.
   b. If the employer ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify the Chief Operations Officer and National Institute for Occupational Safety and Health, at least three months prior to the disposal of the records and shall transmit them to National Institute for Occupational Safety and Health, if required by National Institute for Occupational Safety and Health to do so, within that three-month period. NOTE: Authority cited: Sections 142.3 and 6308; Labor Code. Reference: Sections 142.3 and 6308, Labor Code, and 8 CCR 332.3.

REFERENCES:

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12. https://www.cdph.ca.gov/programs/ohb/Pages/ATDStd.aspx
13. California Department of Public Health (2021). Cal/OSHA Aerosol Transmissible Disease Standards. Retrieved from https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/Pages/ATDStd.aspx
14. Centers for Disease Control and Prevention (2016). Transmission-based precautions. Retrieved from https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html

CROSS-REFERENCED POLICIES AND PROCEDURES:

1. Airborne Infection Isolation Rooms (AIIR)
2. Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu
3. Triage of Patients Suspected of Viral Hemorrhagic Fever (VHF)
4. Interim Guidance For Environmental Infection Control For Patients With Probable/Suspected Viral Hemorrhagic Fever (VHF)

5. Severe Acute Respiratory Syndrome (SARS-CoV) or Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Infection Control Recommendations Hospitalized Patients
6. Tuberculosis Exposure Control Plan
7. Employee Health NIHD Workforce Tuberculosis Surveillance Program
8. Care and Donning of a Powered Air Purifying Respirator (PAPR)
9. Infectious/Bio-Hazardous Waste: Hazardous Substance Communication Program
10. Infectious/Non-Infectious Waste Disposal Procedure PAPR Respirator Inspection Record

RECORD RETENTION AND DESTRUCTION:
As described in the Policy and Procedure example fit test results.

Supersedes: v.9 Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program & Northern Inyo Healthcare District COVID-19 Prevention Program (CPP)

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: NIHD Antibiotic Stewardship Committee Charter		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 06/24/2024	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

COMMITTEE PURPOSE

1. To comply with evidence-based guidelines or best practices by promoting the appropriate use of antimicrobials by selecting the appropriate agent, dose, duration and route of administration in order to improve patient outcomes, while minimizing toxicity and the emergence of antimicrobial resistance.
2. Serves as the foundation of the commitment to continuously improve antimicrobial stewardship practices at Northern Inyo Healthcare District (NIHD) and to monitor outcomes and antimicrobial use.

COMMITTEE MEMBERSHIP

In order to assure appropriate and quality utilization of antimicrobial agents The Antimicrobial Stewardship Committee has developed a multi-disciplinary team that consists of the following:

1. Chief Executive Officer (s) (ad hoc)
2. Physician: Chair
3. Director of Pharmacy: Co-chair
4. Medical staff representatives
5. Clinical Microbiologist
6. Infection Prevention staff member
7. Quality Assurance and Performance Improvement
8. Clinical Informatics and/or Information Technology (ad hoc)
9. Pharmacy representative (ad hoc)
10. Nursing representative (ad hoc)
11. Remote consultation services as needed (ad hoc)
12. Representative from Sharp (ad hoc)

Note: One individual may fulfill multiple roles within the subcommittee

FREQUENCY OF MEETINGS

The team meets quarterly no less than three times a year. If unable to meet, approval of documents must occur electronically and minutes recorded

COMMITTEE GOALS 2024

1. Improve communication and documentation within Electronic Health Record on antibiotic therapy with Inpatient Med-Surg and ICU patients.
2. Decrease mixed flora urine cultures throughout the organization.

Note: For further details on annual goals see attachment in Antibiotic Stewardship Program Policy

The following are the ongoing *LONG-TERM/ONGOING* goals for NIHD ASP plan:

1. Minimize the development of antimicrobial resistance by selecting the appropriate antibiotics and eliminating redundant and unnecessary antibiotic use.
2. Control of Clostridium difficile infections and the emergence of multi-drug resistant organisms (MDROs)
3. Develop the ASP Team. Our team is committed to working on our intra-team communication and strengthening our team through internal development and team-building.
4. Support the education of healthcare providers, partners and patients about antimicrobial stewardship practices, including antimicrobial resistance and appropriate antimicrobial use.
5. Drive Performance with Data. To bring managers, clinicians and staff together to review antibiotic stewardship data and related clinical adverse occurrences to identify problems and make improvement.
6. Collaboration/Partnerships. Develop relationships with external organizations.

COMMITTEE RESPONSIBILITIES

1. Developing, approving and overseeing the implementation of the Antibiotic Stewardship Program plan and related tactical/action plans.
    a. Review of processes pertaining to core strategies for conducting antimicrobial stewardship including
        - Prospective audit with intervention and feedback to the physician which may include but is not limited to provider education on antimicrobial resistance patterns, antimicrobial dosing, duration, spectrum of activity, compliance to national and institutional guidelines, etc.
        - Formulary restriction and pre-authorization requirements
2. Evaluate and make recommendations for improvement to ASP plan and send to the Pharmacy & Therapeutics Committee for approval.
3. The ASP Subcommittee is responsible to report at least annually to the following committees:
    a. Pharmacy & Therapeutics
    b. Infection Prevention Committee
    c. Quality Council
    d. Medical Staff
    e. Medical Executive Committee
4. Establishing measurable objectives based upon priorities identified through use of established criteria for improving the ASP Program
5. Reporting to the Board of Directors on ASP activities of NIHD at least annually

RETENTION AND DESTRUCTION OF RECORDS

Keep at least three years or until next CDPH and Joint Commission Surveys

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: NIHD Antibiotic Stewardship Program Plan		
Owner: Manager Employee Health & Infection Control	Department: Pharmacy	
Scope: District Wide		
Date Last Modified: 06/24/2024	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/17/2016	

SECTION 1: INTRODUCTION

The Antibiotic Stewardship Program (ASP) purpose is as follows:

1. To comply with evidence-based guidelines or best practices by promoting the appropriate use of antimicrobials by selecting the appropriate agent, dose, duration and route of administration in order to improve patient outcomes, while minimizing toxicity and the emergence of antimicrobial resistance.
2. Serves as the foundation of the commitment to continuously improve antimicrobial stewardship practices at Northern Inyo Healthcare District (NIHD) and to monitor outcomes and antimicrobial use.

SCOPE OF SERVICE AND AUTHORITY

1. The scope of this plan will include all patient care services.
2. The NIHD Board of Directors delegates the development, implementation and evaluation of the ASP plan to, Antibiotic Stewardship Committee, the Medical Staff and the District and is ultimately responsible for the quality of patient care and services provided.
3. The NIHD Chief Executives delegates ASP activities to executive committees. The Northern Inyo Healthcare District delegated Medical Staff member and Pharmacy Department are charged with participating in the Antibiotic Stewardship Plan to achieve quality patient care and compliance with regulatory/accreditation organizations.
4. Medical Staff members will contribute to all ASP activities through Medical Staff Service committees, project team activities and by assuming leadership roles, as necessary, in ASP processes and activities. The ASP Committee is a sub-committee of the Pharmacy & Therapeutics Committee.
5. The following ASP Plan serves as the foundation of the commitment of NIHD to continuously improve the use of antimicrobials and related patient outcomes.

DEFINITIONS AND PRINCIPLES

Antimicrobial Stewardship: Is a coordinated program that ensures the optimal selection, dosage, and duration of antimicrobial treatment that results in the best clinical outcome for the treatment or prevention of infection, with minimal toxicity to the patient and minimal impact on subsequent resistance

Antimicrobial Stewardship Program: Is coordinated through a subcommittee which is a multi-disciplinary workgroup that reports through Pharmacy and Therapeutics or a similar hospital committee and is charged with

the responsibility of promoting optimal antimicrobial utilization. The team meets quarterly no less than three times a year. If unable to meet, approval of documents must occur electronically and keeping of minutes

ANITMICROBIAL MANAGEMENT PRINCIPLES

Antibiotic stewardship takes a systematic approach based on the following principles.

1. Therapeutic decisions regarding the prescription of antimicrobials will be based on best available evidence.
2. Prescribed antimicrobials will be of the narrowest spectrum possible for achieving the intended effect.
3. Dosage, route and frequency of prescribed antimicrobials will be appropriate for the individual patient, as well as the site and type of infection.
4. The duration of antimicrobial therapy will be defined and/or regularly reviewed (based on evidence-based guidelines and clinical improvement)
5. Monotherapy is used in most indications, where clinically appropriate.

CORE ELEMENT 1: LEADERSHIP COMMITEMENT

In order to assure appropriate and quality utilization of antimicrobial agents the Antimicrobial Stewardship Committee has developed a core multi-disciplinary team that consists of the following:

1. Chief Executive Officer (s) (ad hoc)
2. Physician: Chair
3. Director of Pharmacy: Co-chair
4. Medical staff representatives
5. Clinical Microbiologist
6. Infection Prevention/Employee Health Manager
7. Quality Assurance and Performance Improvement
8. Clinical Informatics and/or Information Technology (ad hoc)
9. Pharmacy representative (ad hoc)
10. Nursing representative (ad hoc)
11. Remote consultation services as needed (ad hoc)
12. Representative from Sharp (ad hoc)

CORE ELEMENT 2: ACCOUNTABILTIY/RESPONSIBILITES TEAM & COMMITTEE

The Antibiotic Stewardship Committee responsibilities:

1. Developing, approving and overseeing the implementation of the Antibiotic Stewardship Program plan and related tactical/action plans.
2. Evaluate and make recommendations for improvement to ASP plan and send to the Pharmacy & Therapeutics Committee for approval.
3. The ASP Subcommittee is responsible to report to the following committees:
    a. Pharmacy & Therapeutics
    b. Infection Prevention Committee
    c. Quality Council
    d. Medical Staff
    e. Medical Executive Committee

4. Establishing measurable objectives based upon priorities identified through use of established criteria for improving the ASP Program
5. Reporting to the Board of Directors on ASP activities of NIHD at least annually

Pharmacy and Therapeutics Committee:

- Provide feedback and approve antibiotic stewardship strategies recommended by the ASP Committee
- Provide Drug Expertise related to antibiotic use and resistance
- Provide feedback and approve NIHD antibiogram reporting
- Provide feedback and approve Antibiotic Stewardship Program performance measurement systems.

Infection Preventionist and Control Committee:

- Provide feedback on antibiogram reporting.
- Provide feedback and approve infection control strategies, including strategies that contribute to antibiotic stewardship.
- Provide feedback and approve infection control performance measurement systems.

Quality Council:

- Provide feedback and collaboration with performance measurements.

MULITDISPLINARY TEAM RESPONSIBILITES

Board of Directors responsibilities:

- Supporting and guiding implementation of ASP activities at NIHD
- Reviewing, evaluating and approving the ASP plan annually

Chief Executive Officer (s) responsibilities:

- Support antibiotic stewardship activities financially and through planned coordination and communication of the results of measurement activities related to initiatives. Leaders, through a planned and shared communication approach, ensure the Board of Directors, staff, recipients and family members have knowledge of and input into ongoing ASP initiatives, as a means of continually improving performance.

Physician Chair has the following responsibilities

- Provides oversight of ASP Committee functions including development and implementation of ASP based on nationally recognized guidelines.
- Monitor and improve the use of antibiotics.
- Communicate and collaborate with District medical staff, nursing, pharmacy, leadership, infection prevention, and quality departments.
  Provide education to medical staff, pharmacy, and nursing staff on the practical applications of antibiotic stewardship guidelines, and polices.

Pharmacy Co-Chair and Pharmacists

- Daily monitoring of patients receiving selected antimicrobials.
- Daily monitoring of microbiological data.
- Collect and document accurate drug allergy history

- Renal dosing of antimicrobials.
- Provides guidance on antimicrobial selection in accordance with antibiogram and with consideration of infection source and diagnosis.
- Collaborate with physicians regarding adjustment of antimicrobial therapy related to the following the "4D's" of optimal antimicrobial therapy:
    - Right Drug
    - Right Dose
    - De-escalation to pathogen directed therapy
    - Right Duration of therapy
- Provides education to practitioners, staff, and patients on the antimicrobial stewardship program, which may include information about resistance, antibiotic restrictions, and optimal prescribing.

Physicians have the following responsibilities:

- Prescribe appropriate antibiotics.
- Provides monitoring of patients receiving antimicrobials, as specified by ASP policies and procedures.
- Ensure proper techniques when collecting cultures.
- Collect and document accurate drug allergy history.

Microbiologists have the following responsibilities:

- Provides guidance on the proper use of tests and the flow of results.
- Collaborates with clinicians to ensure that lab reports present data in a way that supports optimal antibiotic use.
- Contributes to antibiogram development and education.
- Educates healthcare workers on the proper use, ordering and interpretation of laboratory results.

Infection Prevention have the following responsibilities:

- Coordinates District-wide data collection and reporting for infection control data to external agencies and internal departments and committees, as appropriate. This data may include metrics relevant to the ASP, such as C. difficile infections.
- Collaborate with healthcare personnel to achieve highly compliant standard and transmission-based precautions practices aimed at preventing cross transmission of pathogens.
- Promote hand hygiene.
- Monitor Multi-drug resistance organism's patterns.
- Provides education to practitioners, staff, and patients on the antimicrobial stewardship program, which may include information about resistance and antimicrobial use.
- Develop and implement care bundle checklists to reduce the risk of developing device or procedure-related infections.
- Incorporate stewardship activities into the annual infection prevention risk assessment, based on facility antibiogram, outbreak investigations, and antimicrobial/microbe focus reviews.

Nurses responsibilities

- Prepare, administer prescribed antibiotics, and monitor drug side effects.
- Ensure proper techniques when collecting cultures.
- Ensure patient is in correct transmission-based precautions.
- Educate patients and family on antibiotic use.
- Prompt discussion of antibiotic treatment, indication, and duration.
- Educate patients, visitors, and staff on importance of hand hygiene.
- Collect and document accurate drug allergy history.

Clinical Informatics and Information Technology have the following responsibilities:

- Assist with integration of IT/Informatics ASP related system changes into work processes.
- Incorporation of ASP clinical decision support systems into Electronic Health Records (HER) or other Information Technology systems.
- Incorporation of ASP related clinical pathways/guidelines into EHR/CPOE or other IT systems.

Quality Assurance & Performance Improvement Department has the following responsibilities:

- Collaborate with ASP team members to help develop data collection and reporting plans ASP metrics and scorecards/dashboards.
- Work collaboratively with ASP team members, providers, and staff when ASP issues are identified.

Remote Consultation Services has the following responsibilities:

- Provide clinical guidance on antibiotic use.

CORE ELEMENT 3: DRUG EXPERTISE

Appoint pharmacists, ideally as the coleader of the ASP, to help lead implementation efforts to improve antibiotic use. See above Provider Champion, Pharmacist, and Pharmacy Therapeutic Committee responsibilities.

CORE ELEMENT 4: ACTION

The Antibiotic Stewardship Subcommittee develops relationships and collaborates with external partners such as remote consultation services and infectious disease providers**.** Provide prospective audit with intervention and feedback to the physician, which may include but is not limited to provider education on antimicrobial dosing, duration, antibiotic resistance patterns, and compliance with national and institutional guidelines.

CORE ELEMENT 5: TRACKING

Monitor antibiotic prescribing and resistance patterns utilizing the below:

- Annual Antibiogram
- NHSN Antibiotic Use (AU) and Antibiotic Resistance (AR) Module

CORE ELEMENT 6: REPORTING

Report at least annually information on antibiotic use and resistance to prescribers, pharmacists, nurses, and hospital leadership at the below committees.

- Pharmacy and Therapeutics
- Infection Prevention
- Quality Council
- Medical Staff
- Medical Executive
- Board of Directors

CORE ELEMENT 7: EDUCATION

Provide education to prescribers and other relevant staff regarding evidenced-based guidelines or best practices including antimicrobial management should occur upon hire and at minimum annually thereafter. Examples of education could include the following:

- Electronic Learning Management System
- Medical Staff committee meetings
- Web-based training
- One-on-one training

- Talking Points
- Resources available NIHD intranet
- Department meetings

ANTIBIOTIC STEWARDSHIP ANNUAL AND ONGOING PLANS

ANNUAL ANTIBITOICS STEWARDSHIP PLAN/GOALS (SEE ATTACHMENT)

The ASP Committee identifies and defines goals and specific objectives to be accomplished each year.

ONGOING GOALS & OBJECTIVES

The following are the ongoing *LONG-TERM* goals for NIHD ASP plan:

- Minimize the development of antimicrobial resistance by selecting the appropriate antibiotics and eliminating redundant and unnecessary antibiotic use.
- Control of Clostridium difficile infections and the emergence of multi-drug resistant organisms (MDROs).
- Develop the ASP Team. Our team is committed to working on our intra-team communication and strengthening our team through internal development and team-building.
- Support the education of healthcare providers, partners and patients about antimicrobial stewardship practices, including antimicrobial resistance and appropriate antimicrobial use.
- Drive Performance with data to bring managers, clinicians and staff together to review antibiotic stewardship data and related clinical adverse occurrences to identify problems and make improvement.
- Collaboration/Partnerships. Develop relationships with external organizations.

REFERENCES:

1. Centers for Disease Control and Prevention. (2020). Implementation of Antibiotic Stewardship Core Elements at Small and Cortical Access Hospitals. Retrieved from https://www.cdc.gov/antibiotic-use/core-elements/small-critical.html
2. Centers for Disease Control and Prevention. (2023). Core Elements of Hospital Antibiotic Stewardship Program. Retrieved from https://www.cdc.gov/antibiotic-use/core-elements/hospital.html
3. Centers for Medicare & Medicaid Services (CMS). 7/6/2022. Infection Prevention and Control and Antibiotic Stewardship Program Interpretive Guidance Update. Retrieved from https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/infection-prevention-and-control-and-antibiotic-stewardship-program-interpretive-guidance-update
4. The Joint Commission. (January 2024). Standards and Elements of Performance. Retrieved from https://e-dition.jcrinc.com/ASearch.aspx
    - Infection Control IC.01.01.01: The critical access hospital identifies the individual(s) responsible for the infection prevention and control program. EP 4
    - Leadership LD.01.03.01 EP 27: The governing body is ultimately accountable for the safety and quality of care, treatment, and services.
    - Medication Management MM.09.01.01 EP 10-21: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Quality Assurance & Performance Improvement (QAPI) Plan
2. Medication Dosing in Renal Failure

3. Medication Reconciliation
4. Plan to Eliminate or Substantially Reduce Medication-Related Errors (MERP) Infection Prevention Plan*
5. Adult Vancomycin Dosing
6. Medication Dosing in Renal Failure
7. Pharmacist Clinical Interventions
8. Formulary System
9. Multidrug Resistant Organism (MDRO) Control Plan

RECORD RETENTION AND DESTRUCTION:

Keep at least three years or until CDPH and Joint Commission Surveys

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Chaperone Use for Sensitive Exams		
Owner: Manager of Diagnostic Imaging Services	Department: Diagnostic Imaging	
Scope: District Wide		
Date Last Modified: 07/11/2024	Last Review Date: 07/03/2024	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/20/2021	

PURPOSE: To provide a standardized safe patient care environment for patients during a sensitive exam or procedure.

POLICY:

1. It is the policy of Northern Inyo Healthcare District (NIHD) and Northern Inyo Healthcare Associates (NIA) to provide and utilize chaperones during sensitive exams or procedures and at the request of the patient, their legal representative and/or clinician.

    a. The use of a chaperone during a sensitive exam provides reassurance to patients of the professional nature of the exam and enhances patient comfort, privacy, security and dignity. A patient or their legal representative may request a chaperone for any examination or procedure.
    b. A chaperone's presence may also provide protection to clinicians against unfounded allegations of an unprofessional nature. A clinician may request a chaperone for any examination or procedure. Should the patient decline chaperone, the clinician may decline to perform the sensitive exam and will notify a supervisor/manager/leader.
    c. Patients are given the option to request a chaperone prior to beginning the exam or procedure.

2. Patients may opt out of having a chaperone present during a sensitive exam or procedure. Clinicians will record patient declined offer of chaperone within patient's medical record. (see 1b.)

    a. Parents may not opt out of a chaperone for their adolescent child.

3. Patient companions, parents or spouses shall not fulfill the role of chaperone.

    a. EXCEPTION: A family member may serve as a chaperone for a pediatric patient (age 0-10) examination except for examinations or procedures where there is placement of finger(s), speculum, swabs, or any other instruments into the genitalia or rectum or if there is a suspicion of abuse.
    b. Patient companions, parent or spouse may stay in the room at the request of the patient when the situation allows their presence.

4. A chaperone who witnesses inappropriate or unacceptable behavior on the part of the clinician will immediately report this to their manager or another senior manager, even if they did not stop the procedure while it was ongoing. The chaperone will complete an unusual occurrence form (UOR).

5. Staff is responsible for recognizing personal and cultural preferences, which may broaden individual perceptions and requirements to provide a chaperone.

DEFINITIONS:

1. Chaperone: An observer who, by mutual agreement, is present during an examination to advocate for patients' rights such as dignity, privacy and consent while also providing a layer of protection for the practitioner performing the examination and the organization.

    a. A chaperone may be a health professional or a trained unlicensed staff member. This may include medical assistants, nurses, technicians, and therapists.
    b. A chaperone shall be employed by, or on contract with, NIHD or NIA.
    c. Whenever possible, the chaperone should be the gender requested by the patient. The chaperone may also assist the health professional or provide support to the patient with personal hygiene, toileting or undressing/dressing requirements when requested or needed by the patient.

2. Clinician: A Medical Staff Member, Clinical Program Trainee, Advanced Practice Nurse, Certified Nurse Midwife, Physician Assistant, Registered Nurse, Licensed Vocational Nurse, Diagnostic Imaging Tech, Respiratory Therapist, Certified Nurse Aide, Physical or Occupational Therapist and EKG Tech.

3. Patient: A person receiving medical care/services.

    a. Age 0 to 10 years (Neonate and sub-set of pediatric population)
    b. Age 11 thru 18 years (Adolescent for purposes of this policy)
    c. Age 18 years or greater (Adult)
    d. A vulnerable patient – defined as a person who lacks capacity to give informed consent or is unable to protect him or herself from abuse, neglect or exploitation. This includes those who only lack momentary capacity due to sedation.

4. Sensitive exams/ procedures: are any exam/procedure that includes the physical examination of or a procedure involving the genitalia, rectum, or female breast. Other examinations may however be considered by the patient to be intimate due to but not limited by culture and/or beliefs.

    a. Includes insertion of equipment or medication into or on the penis, rectum, urethra or vagina.
    b. EXCEPTION: Nursing care that includes perineal cleansing and care as a part of everyday personal hygiene assistance (e.g. incontinence brief changes, bathing, etc.)

5. Type of Chaperone Consent Options

    a. OPT-IN: A chaperone is not required, but is provided at the request of the patient. The following exam/procedures fall under this category:
        i. Examinations of or procedures to the urethra in both males and females;
        ii. Breast radiology procedures including mammography, ultrasound, interventional and MRI;
        iii. Echocardiograms;
        iv. Standard patient care such as listening to the heart, lungs or placement of cardiac leads.
        v. Examinations related to gynecology and pregnancy in non-vulnerable populations.

    b. OPT-OUT: A chaperone will be present unless declined by the patient in the non-vulnerable adult population. If the clinical staff member is uncomfortable performing the sensitive exam without a chaperone and the patient OPTs OUT, the clinical staff member may refuse to provide the clinical care. The following exam/procedures fall under this category:
        i. Breast examination;
        ii. Palpation of the external genitalia;
        iii. Placement of finger(s), speculum, swabs, or any instruments into the vagina or rectum for vulnerable patients.

c. Mandatory chaperone: A chaperone is mandatory during exams of vulnerable populations. (See Definitions – 3d.) Parent may chaperone for children ages 0 to 10 years with some exception. (See Policy – 3a.)

d. Emergency Situations: Emergency care should not be impeded by this policy.

PROCEDURE:

1. Determine level of sensitive exam or procedure (OPT-IN, OPT-OUT or Mandatory).

2. Confidential conversations should occur prior to or after the sensitive exam, unless the clinical provider or patient request otherwise, allowing the chaperone to exit the room.

3. It is a joint responsibility of the clinician and the chaperone to ensure that the following basic considerations are made:

   a. When appropriate, informed consent process is followed by the medical provider, per NIHD policy. Consent for sensitive exam in obtained verbally and documented in the patient record. Education will be provided and questions answered about the exam/procedure for the patient or guardian/parent. This includes information about option to have a chaperone.
   b. If a patient with decision-making capacity declines a part of or the whole examination, it should not be performed. Documentation of refusal in patient record is required.
   c. Maintenance of privacy and confidentiality is essential. Examinations should occur in a closed room. Ensure the use of a patient gown, curtains, privacy screen/private changing area. Preserve dignity via use of a sheet or drapes for covering body parts discreetly.
   d. Remain alert to verbal and nonverbal cues of distress for the patient.
   e. All exams will follow NIHD infection control standards.

4. Document in the patient record, the chaperone's name or when the patient OPTs OUT of using a chaperone.

5. A chaperone has the right to stop a sensitive procedure, examination or care if they feel that the clinician's behavior is inappropriate or unacceptable.

6. A chaperone who witnesses inappropriate or unacceptable behavior on the part of the clinician will immediately report this to their manager or another senior manager, even if they did not stop the procedures while it was ongoing. The chaperone will complete an UOR.

7. It is the responsibility of the health professional to ensure accurate documentation of the clinical contact, which also includes records regarding the use or refusal of a chaperone.

REFERENCES:

1. University of Michigan Policy regarding use of Chaperones: 6/2019.
2. AMA Principles of Medical Ethics. Adopted June 2016. Chapter 1: Opinions of Patient-Physician Relationships.
3. Paterson, Ron (AAHPRA) Independent review of the use of chaperones During the Physical Examination of the Pediatric Patient. May, 2011; (Pediatrics Volume, 127, Number 5).

CROSS REFERENCE P&P:

1. Consent for Medical Treatment
2. Minors with Legal Authority to Consent

Supersedes: N/A

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: Emergency Management Plan		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: District Wide		
Date Last Modified: 06/12/2024	Last Review Date: 04/21/2022	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/01/2008	

PURPOSE:

Northern Inyo Healthcare District Emergency Management Plan follows the Hospital Incident Command System (HICS) format and is the foundation for the all hazards Emergency Preparedness Program. The Emergency Preparedness Program is comprised of 3 basic elements: 1) An all-hazards risk assessment, 2) Emergency Operations Plan (EOP); and 3) a training exercise program.

The Emergency management Plan is designed to outline the basic infrastructure and operating procedures utilized to mitigate, prepare for, respond to, and recover from emergency situations that tax the routine operating capabilities of the healthcare district. Coordination of planning and response with other healthcare organizations, public health, and local emergency management will be included. The plan also addresses proper plan maintenance, communications, resource and assets management, patient care, continuity of operations, management of staff, evacuations, reunification and contingency planning for utilities failure.

The plan will undergo an annual review process to ensure any plan deficiencies are identified and addressed. An improvement plan will be instituted and maintained to ensure lessons learned and action items identified from exercises and real events are properly addresses and documented.

An emergency incident is defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions or the impact on patient care and treatment activities due to such things as; the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization's ability to provide care.

Northern Inyo Healthcare District (NIHD) will manage all emergency incidents, exercises and preplanned (reoccurring/special) events in accordance with the Incident Command System (ICS) design of HICS. HICS has defined organization and job action sheets to accommodate as many positions as needed, depending on the disaster. In the event of a communitywide emergency, the agency's incident command structure will be integrated into and be consistent with the community command structure. Staff shall receive Incident Command System training appropriate to their level of response and assigned roles and responsibilities to ensure they are prepared to meet the needs of patients in an emergency.

NIHD has established mutual-aid agreements with Mammoth Hospital, Southern Inyo Healthcare District and Toiyabe Indian Health Clinic. In addition, NIHD works in conjunction with hazardous materials response teams, local fire department, local law enforcement, area pharmacies and medical supply vendors.

SCOPE:

The Emergency Operations Plan is designed to guide planning and response to a variety of hazards that could threaten the environment of the NIHD campus or the safety of patient's, staff, visitors, or adversely impact the ability of the organization to provide healthcare services to the community. The plan is also designed to assure compliance with applicable codes and regulations. This plan covers all healthcare district facilities (main building, all outbuildings and clinics) and its implementation is the responsibility of all personnel.

Authority for activating the plan will rest with the designated administrator at the time of any incident in need of plan activation**.** Activation of the plan will be conducted in conjunction with agency command staff as well as local emergency management and public health personnel, when appropriate.

The Emergency Plan consists of the Emergency Operations Plan (EOP) and supporting documents. The EOP is the all hazards response overview, includes concept of operations, and organizational structure. The supporting documents provide more detail on the initial response to priority hazards, threats, and events and operational planning. In addition, this plan will define specific goals and objectives, describe preparedness activities, expand the definitions and roles of the Hospital Command Center, and outline response and recovery strategies to be implemented during an emergency event.

SITUATION OVERVIEW:

Hazard Vulnerability Analysis (HVA)

The Disaster Management Committee with the assistance of other pertinent personnel will conduct an HVA of the operations and environment of NIHD. This assessment process helps to identify the hospitals highest vulnerabilities to natural and man-made hazards so that effective preventive measures can be taken and a coordinated response plan can be developed. The results of the HVA will be reviewed with the Inyo Mono Healthcare Coalition (MIHCC) and other emergency management partners. The HVA is completed annually and results will be shared with the Disaster Management Committee, Senior Leadership, and the NIHD Board of Directors.

The critical access hospital's HVA includes the following:

- Natural hazards (such as flooding, wild fire)
- Human-caused hazards (such as bomb threats or cyber/information technology crimes)
- Technological hazards (such as utility or information technology outages)
- Hazardous materials (such as radiological, nuclear, chemical)
- Emerging infectious diseases (such as the Ebola, Zika, or SARS-CoV-2 viruses)

The top identified hazards for this facility are found below**.** These top five hazards have been shared at the community and regional level for partner awareness.

Rank	Hazard
1	Wild Fire
2	IT Systems Failure
3	MCI
4	Chemical Exposure
5	Earthquake

PLANNING ASSUMPTIONS

The following set of assumptions governs the parameters by which this plan was developed.

- Emergencies can happen at any time.
- Emergencies will differ in type, size, scope, and duration.
- NIHD is ultimately responsible for the safety of its patients and staff. External resources may or may not be available in emergency situations. NIHD must understand how we are incorporated into local, regional, and state plans and coordination efforts to participate in available resource request processes.
- Local, state, and federal departments and other healthcare facilities may provide assistance necessary to protect lives and property, however, these resources may not be available and NIHD will plan to manage the incident ourselves, at least for a period of time.
- While this plan outlines actions that should be taken during emergency situations, staff will need to adapt their actions as appropriate for the specifics of the situation.
- No emergency plan can cover all possible contingencies, this plan should be used as a guide and a planning tool to prepare staff and the organization for the most likely hazards that could occur as based on the Hazard Vulnerability Analysis.
- The plan must be implemented in a flexible manner to be successful.
- Staff will be familiar with the plan and their expected responsibilities.
- Staff will execute their responsibilities as outlined in this plan during the emergency event.
- Proper execution of this EOP will save lives and reduce damage from the emergency event.

CONCEPTS OF OPERATIONS

Incident Management

Incident management activities are divided into four phases: mitigation, planning, response and recovery. The job action sheet of HICS includes sections addressing each phase. The four phases are described below:

Mitigation: Mitigation activities describes the actions taken to reduce or eliminate the severity of an emergency. NIHD's strategies for mitigation are to assess and prioritize specific hazards and identify means to reduce those hazards as the organization's ability allows.

Planning: Describes the training, supplies, and equipment required to initiate full effective response at the time of an emergency. NIHD's planning activities include developing emergency operations plans and procedures, conducting training for personnel in those procedures, and conducting exercises with staff to ensure they are capable of implementing response procedures when necessary.

Response: Response includes those actions that are taken when a disruption or emergency occurs. It

encompasses the activities that address the short-term, direct effects of an incident. Response activities for NIHD can include activating the incident command center and emergency plans, triaging and treating patients, staff, and visitors who have been affected by an incident, and providing support to other community emergency response agencies when needed.

Recovery: Describes the processes for restoring operations to a normal or improved state of affairs by both short and long term efforts. Recovery activities for NIHD may include the restoration of interrupted utility services, non-vital functions, replacement of damaged equipment, facility repairs, organized return of patients into the facility, and reconstitution of patient records and other vital information systems. Another key consideration in the recovery and response phases of an incident is the tracking of staff hours, expenses, and damages incurred as a result of the emergency. Detailed records will be maintained throughout an emergency to document expenses and damages for possible reimbursement or to properly file insurance claims.

Plan Activation

The Emergency Operations Plan will be activated in response to internal or external threats to the facility. Internal threats could include fire, workplace violence, and loss of power/other utility or other incidents that threaten the well-being of patients, staff, and/or the facility itself. External threats include incidents that may not affect the facility directly but have the potential to overwhelm NIHD resources or put the facility on alert.

Persons Responsible for Plan Activation

Once a threat has been confirmed, the employee obtaining the information must notify their unit supervisor or the House Supervisor immediately. Employees can use the Emergency Preparedness Procedures Quick Reference flip chart, also known as the Rainbow Chart, which is found in all areas of the hospital for immediate step by step instructions for several emergency situations.

The administrator or administrator on call, and the nursing supervisor on duty, have authority to activate the Incident Command Center (ICC) and initiate all or portions of the emergency operations plan whenever a defined emergency exists. The person activating the emergency plan or Emergency Operating Center (EOC), serves as the Incident Commander until relieved by a senior administrator, or relinquishes responsibility to another individual for breaks or rest periods. It is better to activate the EOC early, and close it soon thereafter, then to delay activation and try to catch up with rapidly moving events.

Position Responsible for Emergency Operations Plan Activation

Position/Title	Contact Number
Primary: Administrator or AOC House Supervisor	See call sheet for AOC cell 760-920-3392 (Sup cell)

The healthcare district may receive three principle notifications: Advisory, Alert and or Activation.

- **Advisory** is given when no system response is needed but the potential for a response exists.
- **Alert** is given when a response is likely or imminent and should prompt an elevated level of response preparedness.
- **Activation** is given when a response is required.

The local Public Health Department or local emergency management office will usually receive these notifications at which time NIHD will be informed.

Important information to obtain as soon as possible should include but is not limited to:

- Type of incident, including specific hazard/agent, if known
- Location of incident
- Number and types of injuries
- Special actions being taken (e.g., decontamination, transporting persons)
- Estimated time of arrival of first-arriving Emergency Medical Service units.

Alerting Staff (On and Off Duty)
To notify staff that the EOP has been activated, those within the facility will be contacted first through the internal communication systems, if functioning, such as overhead paging, radios, and email.

Staff away from the facility at the time of activation will be contacted via the simplified texting alert system, and phone trees. The individuals responsible for contacting staff include the House Supervisor and individual department directors or managers.

Alerting Response Partners
NIHD works closely with several external partners. The IC or Disaster Manager will be the individual(s) responsible for contacting these external agencies to notify them that the EOP has been activated.

ORGANIZATION & ASSIGNMENT OF RESPONSIBILITIES

During an event, specific roles and responsibilities will be assigned to individual positions/titles as well as facility departments.

Essential Services
The table below identifies the department roles and responsibilities during plan activation.

Roles and Responsibilities

Essential Services	Roles and Responsibilities	Point of Contact by Position	Secondary Point of Contact
Administration	Incident Command	Chief Executive Officer	Chief Operations Officer
Medical Staff	Direction of Medical Staff Services	Chief of Emergency Medicine	Chief Medical Officer/Chief of Staff
Dietary	Emergency Food Provisions	Dietary Manager	Dietician
Housekeeping	Preparation and distribution of EVS related supplies.	Manager of EVS	EVS/Laundry Assistant Manager
Maintenance	Facilities Management & Utilities Operations	Director of Facilities	Maintenance Manager
Nursing	Patient Care Operations	Chief Nursing Officer	Inpatient/Outpatient Director of Nursing
Pharmacy	Emergency disposition of medications.	Pharmacy Director	Staff Pharmacist
Safety & Security	Maintain safe and secure facilities to operate under emergent situations.	Director of Facilities	Maintenance Manager

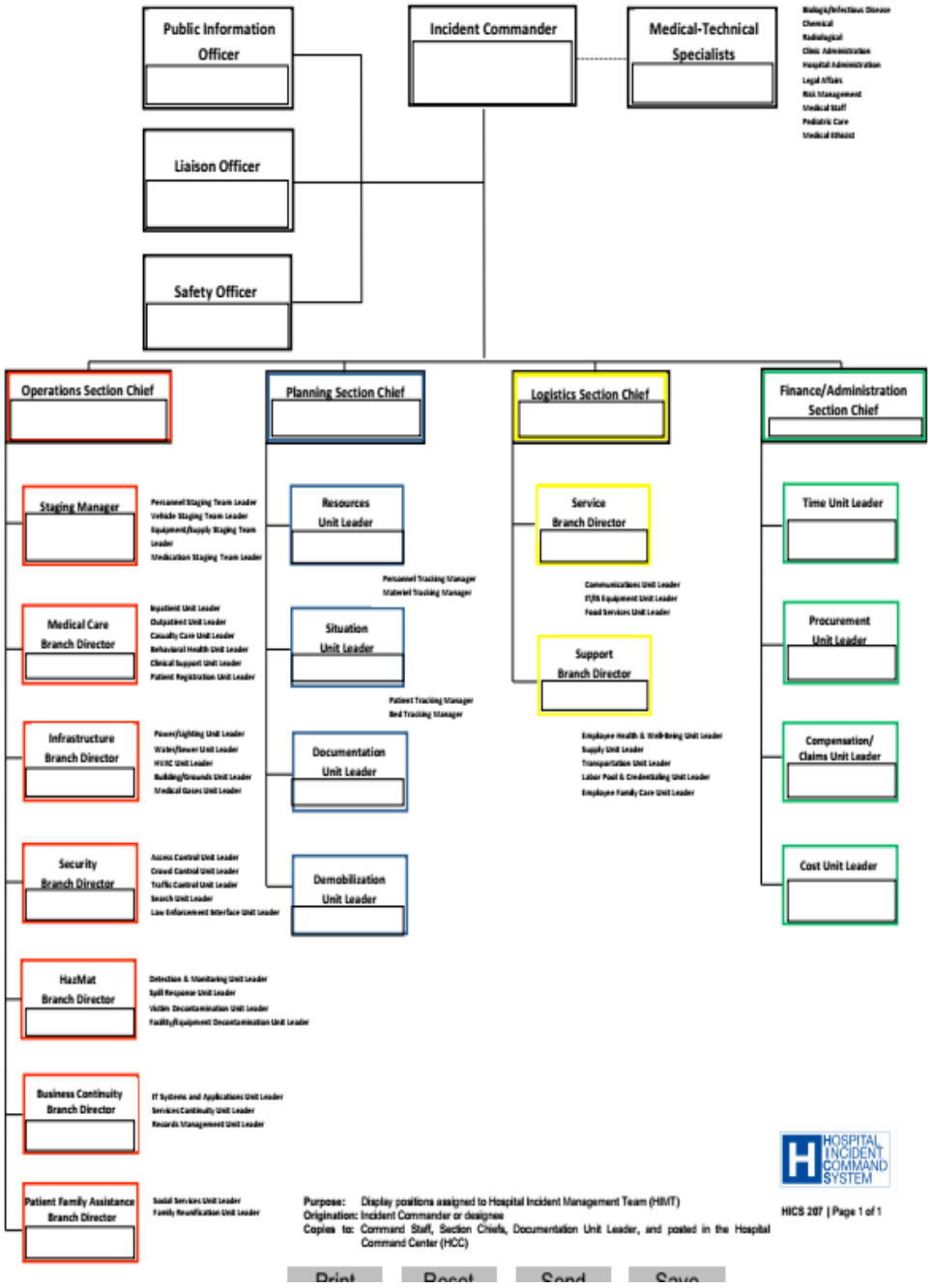
Materials Management/Supplies	Provide additional supplies as needed.	Director of Purchasing	Designated Administrator

Positions
Identifying and assigning personnel in the HICS system depends a great deal on the size and complexity of the incident. The HICS is designed to be flexible enough so that the number of staff needed to respond to an incident can be easily expanded or contracted. HICS Form 203 is used to document and assign staff to HICS specifics positions.

DIRECTION, CONTROL, AND COORDINATION

NIHD will coordinate emergency operations from the facility command center. The primary hospital command center will be located in the Second Floor Conference Room (H2063). Should an alternative location be needed off campus, NIHD can utilize one of their off-site locations (Birch Street, Joseph House, etc.) or any of alternative evacuation sites as described in the evacuation section of this document.

Command Structure
Command will be organized according to the ICS model to help manage the implementation of emergency responses and to integrate the facility response with the community and other health care providers. The ICS model plan is developed to manage emergency responses that have unpredictable elements. These are determined as part of the HVA and priority analysis. Plans that stand alone are designed to allow immediately available staff to effect instant activation and to manage the consequences. Most others are designed to use the ICS for emergency management.


Public Information Officer
Incident Commander
Medical-Technical Specialists
Liaison Officer
Safety Officer
Operations Section Chief
Planning Section Chief
Logistics Section Chief
Finance/Administration Section Chief
Staging Manager
Medical Care Branch Director
Infrastructure Branch Director
Security Branch Director
HazMat Branch Director
Business Continuity Branch Director
Patient Family Assistance Branch Director
Resources Unit Leader
Situation Unit Leader
Documentation Unit Leader
Demobilization Unit Leader
Service Branch Director
Support Branch Director
Time Unit Leader
Procurement Unit Leader
Compensation/ Claims Unit Leader
Cost Unit Leader
HOSPITAL INCIDENT COMMAND SYSTEM
Purpose: Display positions assigned to Hospital Incident Management Team (HIMT)
Origination: Incident Commander or designee
Copies to: Command Staff, Section Chiefs, Documentation Unit Leader, and posted in the Hospital Command Center (HCC)
HICS 207 | Page 1 of 1
Print
Reset
Send
Save

HICS Positions with Possible Hospital Staffing Position Candidates

HICS Position	Hospital Position
Incident Commander	Chief Executive Officer Administrator On Call Nursing Supervisor Chief Operating Officer Chief Medical Officer Director of Emergency Medicine
Public Information Officer (PIO)	Chief Executive Officer Administrator Manager of Marketing
Safety Officer	Facilities Manager Maintenance Manager DON Infection Prevention
Liaison Officer	Chief Executive Officer Manager of ED/Disaster Administrator
Operations Section Chief	Chief Nursing Officer Chief Operating Officer DON Inpatient or Outpatient Services Administrator
Medical-Technical Specialist(s)	Chief of Staff DON Infection Prevention Information Technologies

Orders of Succession

Orders of succession ensure leadership is maintained throughout the facility during an event when key personnel are unavailable. Succession will follow facility policies for key facility personnel and leadership.

Key HICS Position Assignments and Orders of Succession

Command and Control	Primary	Successor 1	Successor 2
Shift 1			
NIHD Representative	CEO	COO	CFO
Incident Commander	COO	CEO	CMO
Public Information Officer	Director of Marketing	CEO	COO
Safety Officer	Director of Facilities	Maintenance Manager	Designated Administrator
Liaison	Manager of ED/Disaster	Designated Administrator	Designated Administrator
Operations Section Chief	CMO	CNO	DON
Planning Section Chief	CNO	CMO	COO
Logistics Section Chief	Purchasing Director	Manager of ED/Disaster	Manger of Clinical Engineering
Finance/Administration Section Chief	CFO	Controller	Designated Administrator
Shift 2			
NIHD Representative	DON	House Sup	CNO
Incident Commander	House Sup	Clinical Manager	Designated Administrator
Public Information Officer	Designated Administrator	Director of Marketing	CEO
Safety Officer	Maintenance Manager	Quality Manager	Director of Facilities
Liaison	Quality Admin	HR Director	HR Manager
Operations Section Chief	Clinical Manager	DON	ED/Disaster Manager
Planning Section Chief	Clinical Manager	Designated Administrator	Quality Manager
Logistics Section Chief	Designated Administrator	Designated Administrator	Designated Administrator
Finance/Administration Section Chief	Controller	Designated Administrator	Designated Administrator

Delegation of Authority

Delegation of authority specify who is authorized to make decisions or act on behalf of NIHD leadership and personnel if they are away or unavailable during an emergency. Delegation of authority planning involves the following:

- Identifying which authorities can and should be delegated.
- Describing the circumstances under which the delegation would be exercised and including when it would become effective and terminate.
- Identifying limitations of the delegation.
- Documenting to whom authority should be delegated.
- Ensuring designees are trained to perform the emergency duties.

Emergency Authority Delegation

Authority	Type of Authority	Position Holding Authority	Triggering Conditions
Activate Facility Command Center	Emergency Authority	Administrator on call (AOC)/House Sup.	Immediate Threat, Operations Interruptions
Activate Emergency Annexes and the Emergency Operations Plan	Emergency Authority	Administrator on call (AOC)/House Sup.	Specific Incidents i.e. Power Outage, Active Shooter, etc.
Close facility	Emergency Authority	CEO/COO	Remaining in the facility is unsafe.
Represent facility when engaging Govt. Officials	Administrative Authority	CEO, COO, Compliance Officer	Unannounced Survey, local or national emergency.
Activate facility memorandum of understanding/mutual aid agreements	Administrative Authority	Senior Leadership	Additional resources necessary to operate.

Community-wide Response Involvement
Inyo County is part of the Mutual Aid Region VI (6) of the Southern District of the California Office of Emergency Services (Cal OES). The local emergency response group works with local, county and state planning agencies under Cal OES to define the role each provider will play during an emergency. The anticipated role of NIHD is to function as an acute medical care facility capable of effectively treating many levels of injury/illness. This role might be reduced if environmental circumstances affect the integrity of the campus or the utility systems essential to providing care.

Regional Healthcare Coalition Coordination
NIHD is a member of the Inyo County Unified Command and the Mono Inyo Healthcare Coalition. NIHD participates in regular planning meetings, exercises, and incident review/debriefings.

Both groups are made up of representatives of community emergency response agencies, health care organizations, and other organizations interested in developing coordinated regional emergency response plans. These crucial discussions between key community stakeholders guide the development of the NIHD Emergency Operations Plan and aid in general disaster planning. These groups meet on a regular basis.

INFORMATION COLLECTION, ANALYSIS, AND DISSEMINATION

Information is vital to making good decisions during a crisis. The needed information must be collected in a timely manner, analyzed and disseminated to "need to know" parties to enable them to determine their most appropriate course of action during the incident.

Information is collected and disseminated by various systems which may include:

- Inyo Mono Healthcare Coalition, Inyo County Unified Command, and the California Health Alert Network (CAHAN)
- Local/regional dispatch center
- Local emergency operations centers
- State Public Health Emergency Response Center/State Emergency Operations Center

Essential elements of information contain situational awareness details that are critical to the initial and ongoing response and recovery operations. The elements listed below may not apply to every event, may not be all-inclusive, and may be modified as needed and adjusted per operational period. NIHD is prepared to share this information during a disaster or emergency event with relevant partners:

- Facility operating status
- Facility structural integrity
- Status of evacuations/shelter in-place operations
- Status of critical medical services (e.g., trauma, critical care)
- Critical service/infrastructure status (e.g., electric, water, sanitation, heating, ventilation, and air conditioning)

- Bed or patient status
- Equipment/supplies/medications/vaccine status or needs
- Staffing status
- Emergency Medical Services (EMS) status
- Epidemiological, surveillance or lab data (e.g., test results, case counts, deaths)
- Point of Dispensing (POD)/mass vaccination sites data (e.g., throughput, open/set-up status, etc.)

COMMUNICATIONS

Day to day internal communications are carried out by emails, landline telephones, cell phones, handheld radios, and the internal overhead paging system. Back up communication means include handheld radios and cell phones should landlines and overhead paging systems fail. Internal code alert systems, internal networks, and the overhead paging system are considered vital to the lifesaving functions of the facility and will be considered an emergency if they fail.

External communications are carried out by landline telephones, emails, and cell phones. In the event of a failure of these systems, backup systems such as HAM Radios and Satellite phones, will be utilized.

NIHD has established common equipment, communications and data interoperability resources with emergency medical services (EMS), public health, and emergency management that will be used during incident response. This element will be part of the annual evaluation of NIMS compliance.

NIHD will establish common language that is consistent with language to be used by local emergency management, law enforcement, emergency medical services, fire department, and public health personnel. Plain language will be used in training and tested during drill exercises.

Notification of Civil Authority
Whenever a situation adversely affects NIHD's ability to provide services to the community, the healthcare district notifies appropriate authorities and city-county agencies and coordinates mutual aid and other response activities through the county Emergency Operations Center (EOC), if appropriate, or directly with receiving hospitals.

Several local agencies may play a role in managing an emergency. NIHD maintains a current list of these agencies and key contacts for various kinds of emergency situations. Contacts on the list include police, fire, Emergency Medical Services, local emergency management offices, utility companies and the Red Cross. The Incident Commander, or designee, notifies agencies as appropriate as soon as possible after an emergency response is initiated.

California Department of Health Services requires that all emergency/disaster related occurrences, which threaten the welfare, safety, or health of patients, must be reported to the Department of Health Services, Licensing and Certification Program.

Release of Information
Release of information to the news media follows procedures developed by the Public Information Officer (PIO) who act as spokesperson for the organization. The Incident Commander will release information as

appropriate to the situation. In larger incidents, the assigned PIO for Inyo County EOC may act as spokesperson for the overall emergency event and report healthcare related information on behalf of the District.

Staff Notification
As previously noted, staff is notified of EOP implementation in several ways: overhead page, landline telephone, cellular phones, CAHAN notification, text message, or runners in the healthcare district. Off duty staff, physicians, and other licensed practitioners will be contacted via departmental call trees, e-mail notification, or mass notification system.

NIHD maintains an updated employee directory as well as a communication binder with all relevant authorities contact information.

In the event of an emergency or evacuation, the emergency response plan include a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation:

- Patient's family, representative, or others involved in the care of the patient
- Disaster relief organizations and relevant authorities
- Other healthcare providers

Pertinent medical information is transported with each patient as a hard-copy (HICS-260) form.

MANAGEMENT OF PATIENT CARE ACTIVITY

NIHD has a specific plan that addresses management of patient care activities. The plans include procedures for discontinuation of elective treatment, evaluation of patients for movement to other units, release to home or transfer to other facilities as space is needed, management of information about incoming patients and current patients for planning, patient management, and informing relatives and others; and for transport of patients.

Victims will be admitted through the Emergency Department for initial triage and disposition to appropriate area as their condition warrants. Outpatient and elective procedures may need to be canceled and rescheduled, depending on resource allocation and facility status (i.e. condition of department, availability of staff & supplies) as a result of the emergency. Inpatients will be assessed on admission and placed in the following categories for discharge or transfer:

- **Very High Risk** – could only be cared for in an acute facility
- **High Risk** – could be transferred to an acute care facility
- **Moderate Risk** – would be transferred to another facility
- **Low Risk** – could be transferred home
- **Minimum Risk** – could be discharged immediately

Emergency Locations for Patient Care
All patients will enter through Emergency Department, after triage outside, as appropriate.
Patient Treatment Areas will be assigned as follows unless otherwise stated at the time of Code Triage.

- **Triage Area** – Emergency parking lot adjacent to the Emergency Department
- **Immediate Care Area** - Emergency Department
- **Delayed Care Area** – Rural Health Clinic
- **Minor Care Area** – Pioneer Medical Building
- **Morgue** – To be determined at the time of emergency

Pre-assigned locations of various functions (if activated) are as follows unless otherwise stated at the time of the Code Triage:

- **Healthcare District Command Center** – 2nd Floor Conference Room
- **Labor Pool** – Main Lobby
- **Family Center/Human Services Center** – Rehabilitation Building
- **Press Center** – Administration Meeting Room
- **Dependent Adult/Child Care Center/Pediatric-Safe Area (PSA)** – Rehabilitation Building

Patient Populations
NIHD intends to serve all populations that seek healthcare during emergencies including at-risk populations. NIHD may be forced to curtail or consolidate services offered depending on damage to facilities. Services may be transferred to undamaged areas of the hospital or other area hospitals. At-risk or vulnerable populations may have additional needs to be addressed during an emergency or disaster incident, such as medical care, communication, transportation, supervision, and maintaining independence. As needed based on the situation, NIHD would coordinate with the appropriate jurisdiction to request resources from regional, state, or federal assets to augment/increase care when needed and or available.

Evacuation
A facility evacuation plan is in place and can be implemented in phases. Relocation of staff away from the area of emergency may be undertaken by staff on the spot, moving to areas in adjacent zones. A full evacuation would be implemented if the impact of an emergency renders the healthcare district inoperable or unsafe for occupancy, and would be implemented with the involvement of the Administrator on Call in conjunction with senior leadership.

Shelter in Place
If NIHD administration, along with internal safety and public safety officials, determines that sheltering in place is the safest course of action for patients, staff, and volunteers, the command center will be activated to ensure patient care and staff needs are met. The command center will plan for and ensure care and sustenance needs are met along with ensuring a safe environment.

Chemical and Radioactive Isolation and Decontamination
The management of situations involving nuclear, biological, or chemical contamination is a joint effort between national, state, and local officials and the health care community. NIHD is prepared to manage a limited number of individuals contaminated with hazardous materials and to meet the care needs of others who have been decontaminated by other agencies.

If the facility is contaminated, a contractor experienced in the isolation and decontamination process will be contacted by the Incident Command staff. The Safety Officer, with Public Safety assistance, will assure isolation of the affected area until it is declared safe by appropriate experts.

Reunification
In the event of pediatric surge, mass causality incident, or a disaster that requires activation of a surge/reunification plan, NIHD will work in conjunction with County Unified Command and other pertinent county partners to activate the Concept of Operations (CONOPS) of the Mono & Inyo Healthcare Coalition Pediatric Surge Plan. This plan outlines reunification in detail. Included in the plan is a pediatric identification and tracking system for both accompanied and unaccompanied children, rapid survey protocol to

identify unaccompanied or displaced children, and defined Pediatric Safe Area (PSA) where uninjured, displaced or discharged children can be held until released to a caregiver. All forms, tools and documents are located in the CONOPS document found in the Disaster Planning Binder.

ESSENTIAL NEEDS FOR STAFF AND PATIENTS

Vulnerable Populations: Clinical activities for vulnerable patient populations including pediatric, geriatric, disabled, or have serious chronic conditions will be provided in the customary way but additional emphasis will be placed on security, safety, and mobility in terms of evacuation should it become necessary during an emergency. NIHD plans for the possibility of a surge in patients. Transportation of patients and supplies will be handled by several means, including but not limited to: NIHD care shuttles, local and county EMS, Inyo-Mono Transit Authority, local law enforcement, and local EMS air support.

Food and Other Nutritional Supplies: The Logistics Section will ensure that supplies in-stock, on campus are sufficient. Food service vendors will be notified and updated to provide for essential needs. The Dietary Department handles all food and water acquisition and delivery.

Medications and Related Supplies: Pharmacy handles both the acquisition and delivery of supplies. Pharmacy also has strategic inventory which contains counter measures for organic phosphates, nerve agents, and pesticides.

Medical/Surgical Supplies (including PPE): The Logistics Section in conjunction with the Purchasing Department handles the acquisition of supplies through its vendors and transport via its delivery personnel.

Medical Oxygen and Supplies: NIHD can provide bottles of gases supplied by normal vendors or disaster response contractors, or by a state resource request. NIHD has an emergency plan for medical gas failure.

Potable or Bottled Water: The Dietary Department handles food and water acquisition and delivery. The Dietary Department maintains an inventory of bottled water on campus for emergency use. NIHD can request local and state support for additional potable water as needed.

Personal Hygiene and Sanitary Needs: Personal hygiene and sanitary needs of patients during emergencies will be provided by NIHD. In addition, when water intended for hand washing is not available, the hospital utilizes waterless alcohol-based hand rub, which is maintained in ample supply at the hospital. The alternative means to personal hygiene can be baby wipes, personal wipes, or alcohol-based rubs. The alternative means to sanitation, if toilets are inoperable, is kitty litter, red bags in toilets, or positioning of water barrels and waste collection barrels. Limit changes of bed linen to those patients who have gross soiling. Environmental Services use of daily water will be curtailed as designated by the Manager of Environmental Services.

Management of Behavior Health Patients: During an emergency, NIHD will arrange for mental health consultation to patients through prearranged county services. The NIHD social worker should be made available to attend to the emotional needs of patients while awaiting county services in the event of a disaster. If necessary, patients should be transferred to a specialized behavioral health setting. If transfer of patients is not possible, then staff should be assigned to monitor patients accordingly to NIHD policy.

Surge and Alternative Care Sites

NIHD plans for the possibility of a surge in patients. The surge tent may be utilized for alternate care site. Other care sites may include Jill Kinmont Boothe School; Bishop City Hall, Pine Street School Gym, and the Tri County Fairgrounds. Transportation of patients and supplies will be handled by several means, including but not

limited to: NIHD care shuttles, local and county EMS, Inyo-Mono Transit Authority, local law enforcement, and local EMS air support.

The Incident Command Center works with Operations, Planning and Logistics Chiefs to coordinate appropriate staff to assure required equipment, medication, medical records, staffing communications and transportation are mobilized to support relocation and management of patients at remote sites.

Patient Tracking
NIHD tracks the location of patients on site during an emergency using wristbands, bed assignment, and electronic management systems. HICS 254-Disaster Victim Patient Tracking Form will be utilized.
In the event that the computer system is down, the registration staff will coordinate the use of the Disaster Victim Patient Tracking Form with the START Triage system, both are maintained on paper. NIHD will ensure that all patient identification wristbands (or equivalent identification) is intact on all patients. If patients are evacuated, the HICS 260 - Patient Evacuation Tracking Form will be used. When more than two patients are being evacuated, the HICS 255 - Master Patient Evacuation Tracking Form should be used to gain a master copy of all those that were evacuated. Information on forms should include, but is not limited to: patient/resident name, date of birth, Medicare/Medicaid number, if minor (accompanied or not), evacuation site location, date of evacuation, arrival time at evacuation site, date of return to facility (if known), and comments/notes.

In addition, NIHD will utilize third-party information such as local emergency response agencies and the Red Cross as appropriate to assist families in locating patients.

Staff Tracking
The management chain of command as well as incident command resource management principles will be used to track the location of on-duty staff.

NIHD uses staff identification badges to identify caregivers and other employees during mass casualty or major environmental disasters. All staff presenting to the facility will need to have a visible NIHD ID in order to enter. Staff without ID's must report to the Labor pool, be positively identified, and receive a temporary badge or other approved alternate. Key members of the Incident Command team are issued a vest with the ICS Command Title visible to identify their role in the response. These vests move with the job title as more senior staff become available, and during longer incidents where jobs are handed from staff to staff. The Liaison Officer from the Incident Command team is assigned to work with law enforcement, fire services, emergency management agencies, contractors, the media, and volunteer responders to issue NIHD emergency identification or to determine what form of identification will be required for each responding group.

SAFETY AND SECURITY

NIHD completes security assessments to address vulnerabilities campus wide. The Director of Facilities in conjunction with the in-house Security Team is responsible for the overall planning of the Security Services response in day-to-day operations and during emergency events. If insufficient security staff exists to cope with the emergency, a request for assistance from local law enforcement agencies shall be completed.

NIHD requires the facility to establish a command center, a staging or assembly area, and a perimeter with controlled or monitored access points. The on-duty Security Officer or Incident Commander shall direct other responsibilities as deemed necessary. NIHD security and local law enforcement will maintain access, crowd and traffic control. Volunteers from the labor pool would be used to expand the security force if needed.

The restriction of visitors and guests during critical incidents is a necessary procedure to maintain order, safety, and security for patients, staff and visitors. Upon the notification or realization that an imminent threat to the clinical environment exists, a decision to initiate limited facility access shall be considered through the collaboration of the Administrator on Call, Incident Commander, House Supervisor and the on-duty Security Officer.

The extent of the limited access and entry shall be determined through careful examination of the threat and impact on facility operations.
There are 6 levels of lockdown with varying degrees of access, entry and exit. See Lockdown Policy.

CYBER SECURITY

NIHD has a Cyber Security Incident Response Manual (CSIRM) and Disaster Recovery and Planning (DRP) in place. The purpose of the plan is to have established procedures for managing cyber security incidents that may affect the hospital's information technology systems, staff, patients and visitors. The plan outlines the roles and responsibilities of hospital staff, communication protocols, and incident response procedures.

ALTERNATE SOURCES OF UTILITY SYSTEMS

Alternate emergency plans for supply of utilities for patient care are maintained for these contingencies. Plans include use of emergency power, backup systems for water, HVAC, and medical gas failure. Managers and staff in all departments affected by the plans are trained as part of organizational wide and department specific education. The plans are tested from time to time as part of the regularly scheduled drills of the EOP and actual outages of utility systems.

LOGISTICS

Resources and Assets

Acquiring and Replenishing Food, Water, Medications and Supplies

The amounts and locations of current food, water, pharmaceuticals, medical and non-medical supplies, are evaluated to determine how many hours the facility can sustain itself before needing re-supply. This gives the facility a par value on supplies and aids in the projection of sustainability before terminating services or evacuating if needed supplies are unable to reach the facility. Supplying NIHD in an emergency will be initially satisfied by pulling from local resources. As replenishment becomes necessary, resources will be requested from vendors.

If NIHD is unable to acquire sufficient resources through outside vendors and pre-positioned arrangements to meet the healthcare needs of the community, the Logistics Chief and/or Director of Purchasing will communicate these need to the county and utilize the Medical Health Operation Area Coordination (MHOAC) to help locate resources and replenishments at the state level. If sufficient supplies cannot be acquired through regional or state medical supply, the county emergency management team will provide assistance with coordinating the transfer of patient's to other facilities upon request.

Monitoring Quantities of Resources and Assets

The Logistics Chief and/or assigned staff is responsible for monitoring quantities of assets and resources during an emergency. A Resource Accounting Record form (HICS Form 257) should be used when resources and assets are tracked during an emergency.

96 Hour Sustainability
Establishing the sustainability of resources is crucial to determining if services can be rendered during a disaster for three days, based on the facility's hazard vulnerability analysis (HVA). Resource inventory is currently maintained to provide for approximately 96 hours. If this cannot be sustained through current inventory, agreements are in place with suppliers and vendors for the remaining days. If supplies cannot be obtained, policies and procedures are in place in the event the facility may need to evacuate or temporarily close.

Management and Assignment of Staff
Following a disaster, facility personnel must be accounted for. Their location and status should be ensured by unit supervisors, along with the status and location of all patients. They will be tracked during the emergency plan activation to ensure safety and accountability.

Facility personnel may not be assigned to their regular duties or their normal supervisor during emergency plan activation. They may be asked to perform various jobs that are vital to the operation but may not be their normal day to day duties. The Labor Pool is the designated reporting location for reassignment of available staff and volunteers and will be located in the NIHD main lobby. Staff will be assigned as needed and provided information outlining their job responsibilities and who they report to during the event.

If necessary and appropriate, staff may be reassigned to another campus location. Furthermore, staff may be needed to accompany evacuating patients. Staffing assistance from state agencies can be utilized if needed. In the case that NIHD has the need to use volunteers, NIHD has a plan in place to grant emergency privileges to providers. NIHD may use temporary staffing services or travelers to address staffing needs as well.

The Emergency Department physician on duty at the time of the emergency will be responsible for providing medical services for the "Immediate Care" area. Additional physicians may be called in depending on the number of casualties and the nature of their injuries. If "Delayed Care" and/or "Minor Care" areas are established, a physician will be asked to coordinate medical efforts for these functions. The medical staff reviews the EOP at the Medical Executive Committee annually.

Volunteers are responsible for knowing the overhead page, CODE TRIAGE, for the activation of the emergency preparedness plan. Those volunteers assigned to specific departments are responsible to return to their assigned department, unless released to the labor pool. All other volunteers are responsible for reporting to the labor pool, if activated.

Managing Staff Support Needs
All NIHD personnel are considered essential during emergency response situations. The healthcare district recognizes its responsibility to provide meals, rest periods, housing, and psychological support to staff. In addition, the healthcare district recognizes that providing support such as communication services and dependent care to employees' families during emergency situations allows employees to respond in support of the essential functions of the healthcare district. The Operations Chief, working through the Human Service Director and his/her unit leaders will initiate support programs and activities, based on the demands of the specific emergency including but not limited to:

- Emergency lodging and meals
- Emergency transportation
- Emergency child care
- Psychological and bereavement counseling
- Staff prophylaxis or immunizations

Procedures are in place to address the transportation and housing of staff that may not be able to get to or from the facility during an emergency. In addition, a procedure is in place for incident stress debriefing. Staff who are involved in emergency operations are offered an opportunity to address incident related issues with qualified behavioral health professionals.

Finance
Expenditures will be tracked from the beginning of the disaster to include personnel time, supplies, equipment use, rental of equipment, etc. A designated cost center may be assigned given the duration of the disaster. The Finance Section will have processes in place to ensure the needed tracking occurs. Forms that may be used for expense tracking include HICS 252: Section Personnel Time Sheet, HICS 253: Volunteer Registration, HICS 256: Procurement Summary Report, and HICS 257: Resource Accounting Record.

RECOVERY

NIHD has recovery plans to return operations to normal functions after most emergencies. The recovery plans are activated near the completion of the Emergency Operations Plan (HICS). The Incident Commander will determine the degree of activity required. Preset activity that is activated by the "all clear" includes action by medical records to capture the records of emergency services, capture of costs by patient billing, and return of facilities to their original and normal use. The plans also call for resetting and recovering emergency equipment and supplies, and documentation of the findings of the after the event debriefing. If substantial damage has been done to the facility, plans for reconstruction and renovation will be developed at that point. Documentation of current assets (buildings, equipment, etc.) has been recorded for baseline.

Documentation for FEMA assistance will be based on pictures of damages and repairs, documentation and notes on damages and repairs, newspaper reports and stories, video footage from television stations, and records of all expenditures, receipts, and invoices. Short- term recovery frequently overlaps with response.

Initiation and Recovery
The decision to enter into the recovery stage of an event is made by the CEO/Designated Administrator. In this stage, the hospital will undertake recovery procedures to return the facility to normal operations.

Recovery Protocol
In order to efficiently recover from an event, protocols must be followed. Listed below are protocols important to recovery operations.

Recovery protocols:

- Prioritize health care service, delivery, and recovery objectives by organizational essential functions.
- Maintain, modify, and demobilize healthcare workforce according to the needs of the facility.
- Work with local emergency management, service providers, and contractors to ensure priority restoration and reconstruction of critical building systems.
- Maintain and replenish pre-incident levels of medical and non-medical supplies.
- Work with local, regional, and state emergency medical system providers, patient transportation providers, and non-medical transportation providers to restore pre-incident transportation capability and capacity.
- Work with local emergency management, service providers, and contractors to restore information technology and communication systems.
- Prepare after-action reports, corrective action reports, and improvement plans.

Restoration of Services
The CEO/Designated Administrator will coordinate the restoration of services after an emergency situation affecting the hospital.

Staff/Patient Re-Entry
The CEO/Designated Administrator will work with the California Department of Public Health Licensing & Certification Unit to give approval for the return of staff and patients to the facility.

Staff Debriefing
A debriefing will be conducted within 30 days of the incident to collect lessons learned from the incident or exercise. These lessons learned will be used to revise and update the plan. The ED/Disaster Manager or designee will be responsible for coordinating the debriefing.

After-Action Report
After any real incident or exercise where the emergency operations plan is activated, an after-action report (AAR) will be written. The purpose of the AAR is to document the overall performance of the organization during the exercise or real event. It will contain a summary of the scenario or events, staff actions, strengths, issues, opportunities for improvement, and best practices.

The purpose of the after-action report is to ensure issues and opportunities for improvement are adequately addressed to improve response capabilities to future events. If necessary, an improvement plan will be developed to include a list of issues to be addressed, tasks that will be performed to address them, individuals responsible for completing the tasks, and a timeline for completion.

The ED/Disaster Manager will be responsible for coordinating the development of the after-action report and will ensure identified improvements are completed within the targeted timeframes.

Request for 1135 Wavier
The 1135 waiver allows reimbursement during an emergency or disaster even if providers can't comply with certain requirements that would under normal circumstances bar Medicare, Medicaid or Children's Health insurance program (CHIP). The waiver applies to federal requirements only and not state licensures. Waiver requests can be made by sending an email to the CMS Regional Office in California. Information of the facility and justification for requesting the waiver is required.

PLAN DEVELOPMENT AND MAINTENANCE

The ED/Disaster Manager is the qualified individual to lead the Emergency Management Program and works under the general direction of the Chief Nursing Officer (CNO), the Chief Medical Officer (CMO) and the Chief Executive Officer (CEO). The ED/Disaster Manager in collaboration with the Disaster Management Committee, is responsible for managing all aspects of the Emergency Management Program. The Disaster Management Committee advises senior leadership regarding emergency management issues which may necessitate changes in policies and procedures, orientation or education of personnel and/or purchase of equipment.

The Disaster Management Committee is responsible for the following:

- Oversees the emergency management program
- Provides input and assists in the coordination of the preparation, development, implementation, evaluation, and maintenance of emergency management program.
- Meets quarterly
- Includes multidisciplinary representatives (senior leadership, nursing services, medical staff, pharmacy services, infection prevention, facilities engineering, security, and information technology)

In addition, senior leadership provides direct oversight and support of the Emergency Management Program through the Disaster Management Committee. Senior leadership reviews all after action reports (AAR) and improvement plans related to the emergency management program.

Annual Program Evaluation

The Disaster Management Committee is responsible for performing the annual evaluation of the EOP. The annual evaluation examines the objectives, scope, performance, and effectiveness of the EOP and the HVA. The annual evaluation uses a variety of information sources including reports from internal policy and procedure review, after action reports, and summaries of other activities. In addition, findings by outside agencies, such as accrediting or licensing bodies or qualified consultants, are used. The findings of the annual evaluation lead to changes/improvements in the emergency management plan. The annual evaluation is presented to the Disaster Committee and to senior leadership via the Executive Committee. The emergency management plan is required reading for all NIHD workforce.

Training Program

Each new staff member of NIHD participates in a general orientation that includes information related to the EOP. Examples of such information include; emergency preparedness procedures, job-specific roles, emergency communication plans, Rainbow Chart, and location of emergency supplies and equipment.

The Human Resources Department conducts the general orientation program and is responsible for scheduling, managing and documenting staff completion.

New staff members also receive a department-specific orientation. Each department manager or Clinical Staff Educator (CSE) provides new staff members with a department-specific orientation to their role in the Emergency Management Program. Information specific to the Emergency Management Program is included in the continuing education program. The ED/Disaster Manager in coordination with the Disaster Committee, collaborates with individual department heads to develop content and supporting materials for general and department-specific orientation and continuing education programs.

Exercise Program

NIHD will test its plan and operational readiness at least twice per year, utilizing high hazard scenarios per the HVA. NIHD will participate in a community full scale exercise at least annually; if such exercise opportunity is accessible. If not accessible, the hospital will conduct a full scale exercise. NIHD will also conduct one additional exercise of any type at least annually.

All exercises and real events will be documented using the AAR template. This report shall be completed within 60 days of the exercise or real event. The ED/Disaster Manager will be responsible for coordinating the exercises, after action reporting, and improvement planning. The AAR or improvement plan will be incorporated into the emergency plan as soon as it is feasible. All improvement items will be tracked.

All exercises will incorporate elements of the National Incident Management System and Hospital Incident Command System. Future exercises should be planned and conducted to reflect anticipated hazards, incorporating gaps and improvement action items identified during previous exercises and real events.

Independent Study (IS) IS-100, IS-200, IS-700 and IS-800 are available to all healthcare district personnel likely to have a leadership role in emergency preparedness, incident management, and or emergency response during an incident.

DEFINITIONS

a. **Hospital Incident Command System (HICS)** – The "All Hazards" plan used to manage emergencies. This describes a management method that may be adapted to most emergency situations, both internal and external.
b. **Emergency Operations Plan (EOP)** – The program to identify, plan for, prepare for, drill, recover from, and evaluate the response to the drills and actual emergencies, and to identify processes and elements that may be improved with better planning, equipment, or training.
c. **Emergency -** Emergencies are defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions; or, the impact on patient care and treatment activities due to such things as the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization's ability to provide care.
d. **Hazard Vulnerability Analysis (HVA):** a structured process to evaluate the potential for conditions or events that are likely to have a significant adverse impact on the health and safety of the patients, staff, and visitors of NIH or on the ability of NIH to conduct normal patient care and business activities.

REFERENCES:

1. California Office of Emergency Services (CALOES), (2023) https://www.caloes.ca.gov/

2. Federal Emergency Management Agency (FEMA), ICS-100: Introduction to Incident Command System, (2023) https://www.fema.gov/national-incident-management-system

3. Joint Commission Resources, (2023) Emergency Management in Healthcare: An All Hazards Approach. https://www.jointcommission.org/resources/patient-safety-topics/emergency-management

4. Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH), (2023) Emergency Management Reference Guide https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

5. Centers for Medicare Services (2023) 1135 Waivers Emergency Preparedness https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135Waivers

CROSS REFERENCED POLICIES AND PROCEDURES:

1. HICS Organization Chart
2. Credentialing Health Care Practitioners in the Event of a Disaster
3. Emergency Room Overcrowding
5. Capacity Management: Patient Surge
6. Evacuation Policy
7. Emergency Response Plan-Medical Gas Failure
8. Emergency Response Plan-HVAC Failure
9. Lockdown Plan
10. Active Shooter
11. Disaster Management Committee
12. Disaster Plan Perioperative Unit
13. Sterile Processing Disaster Plan
14. Triage of Patients Suspected of Ebola
15. Cyber Security Incident Response Manual

RECORD RETENTION AND DESTRUCTION: Emergency Operation Plan documents need to be retained for 15 years.

Supersedes: v.5 Emergency Management Plan

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Mobile Intensive Care Nurse (MICN)		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: Emergency Department RNs		
Date Last Modified: 03/01/2022	Last Review Date: 07/03/2024	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/1995	

PURPOSE:

To allow the MICN to give immediate direction by radio to the Advanced Life Support (ALS) provider following the protocols as set forth by the California State Emergency Medical Authority (EMS), administered locally by the Inland Counties Emergency Medical Agency (ICEMA), and approved as described by ICEMA.

POLICY:

The ALS providers are responsible for giving a patient care report for any patient contact. The MICN on duty at Northern Inyo Hospital emergency department (ED) shall have the necessary authority to give direction to the ALS providers by radio as outlined in the protocols. This policy allows that the MICN at Northern Inyo Hospital will have the necessary authority to follow current protocols as outlined by this policy to give direction to the ALS providers by radio.

The emergency department nurse manager, pre-hospital liaison nurse (PLN) and the base station hospital director (BSD) or designee will review the protocols prior to being instituted. If the BSD, or ED physician has concern over a particular protocol that issue will be addressed in the Emergency Services Committee, and the committee's decision will be forwarded to ICEMA. If agreed upon, that concern will be noted as an exception to the protocols for the MICN to follow. This exception will be placed in the appropriate place in the protocol manual for direction in the ED, and all MICN's will be notified of the exception.

PROCEDURE:

MICN's will have current understanding of approved protocols and will refer to the protocol manual located in the ED when any question about protocol direction arises. All MICNs will complete the requirements for MICN certification or recertification. The protocol manual will be updated as new protocols are approved, and a copy of the current protocols will be available in the main ED, near the radio at all times. This book will be updated as protocols and exceptions to protocols are made.

DOCUMENTATION:

MICN shall document all ALS contacts on the MICN run sheet and pre-hospital log. The MICN shall also be responsible for any other pertinent paperwork relating to ICEMA policy.

REFERENCE:

1. LALS/ALS ICEMA (EMS Agency) Protocol, Base Hospital Designation, Health and Safety Code Division 2.5 1797.56

RECORD RETENTION AND DESTRUCTION: Record retention will be maintained for 6 years as per California Hospital Association recommendations.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Pre-Hospital Care Policy
2. ICEMA Policy Procedure and Protocol Manual

Supersedes: v.3 MICN Guidelines

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: DI - MRI Safety Plan		
Owner: Manager of Diagnostic Imaging Services	Department: Diagnostic Imaging	
Scope: All Hospital Staff		
Date Last Modified: 04/21/2022	Last Review Date: 07/03/2024	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date: 07-25-2005	

Introduction

MAGNETIC RESONANCE (MR) Safety Manual's purpose is to establish MR safe practices from a growing awareness of the MR environment's potential risks and adverse events involving patients, equipment, and personnel. The American College of Radiology (ACR) manual on MR Safety remains the key document on industry standards for safe and responsible guidelines in clinical MR environments. Northern Inyo Healthcare District (NIHD) MR department's intent is to follow ACR Guidance Document on MR Safe Practices from 2020. The intent of this plan and cross referenced procedures is to assist NIHD staff, physicians, and departments to help prevent adverse staff and patient outcomes relating to medical procedures in MRI.

A. Establish, Implement, and Maintain Current MR Safety Policies and Procedures:

1. NIHD's MR Department will maintain and implement safety procedures regarding our current GE Signa 1.5-tesla magnet. This MRI safety plan is directly associated with and inclusive of all MRI Safety Procedures listed in the cross referenced policy and procedures section of this plan.
2. Cross referenced procedures will be reviewed annually as part of this MRI Safety Plan.
3. Cross referenced procedures and MRI Safety Plan will be reviewed with the introduction of any significant changes in safety parameters of the MR site (e.g., adding faster or stronger gradient capabilities, higher RF duty cycle studies, etc.)
4. NIHD's Magnetic Resonance Medical Director(MRMD) is responsible for ensuring that MR safe guidelines and operations are established and maintained as current and appropriate for the site. The MRMD shall be responsible for the formulation and application of policies and procedures that ensure the safety of patients, MRI staff, and others in the MRI environment.
5. The MRMD is responsible to delegate MRI safety-related tasks to the Magnetic Resonance Safety Officer (MRSO) who is responsible for the day-to-day implementation of the site's safety policies.
6. The MRSO must be trained and experienced in MRI and MRI safety, but need not be a medical physician. It is the responsibility of the site's administration to ensure that the policies and procedures that result from these MR safe practice guidelines are implemented and adhered to at all times and by all of the site's personnel.

7. Procedures will be in place to ensure that any and all adverse events, MR safety incidents, or "near incidents" that occur in the MR suite are reported to the MRMD in a timely manner and used in continuous quality improvement efforts. MRI incidents will be reported to the Radiology Services Committee through the Radiation Safety / MR Safety Committee meeting.

REFERENCES:

MRI Safety References

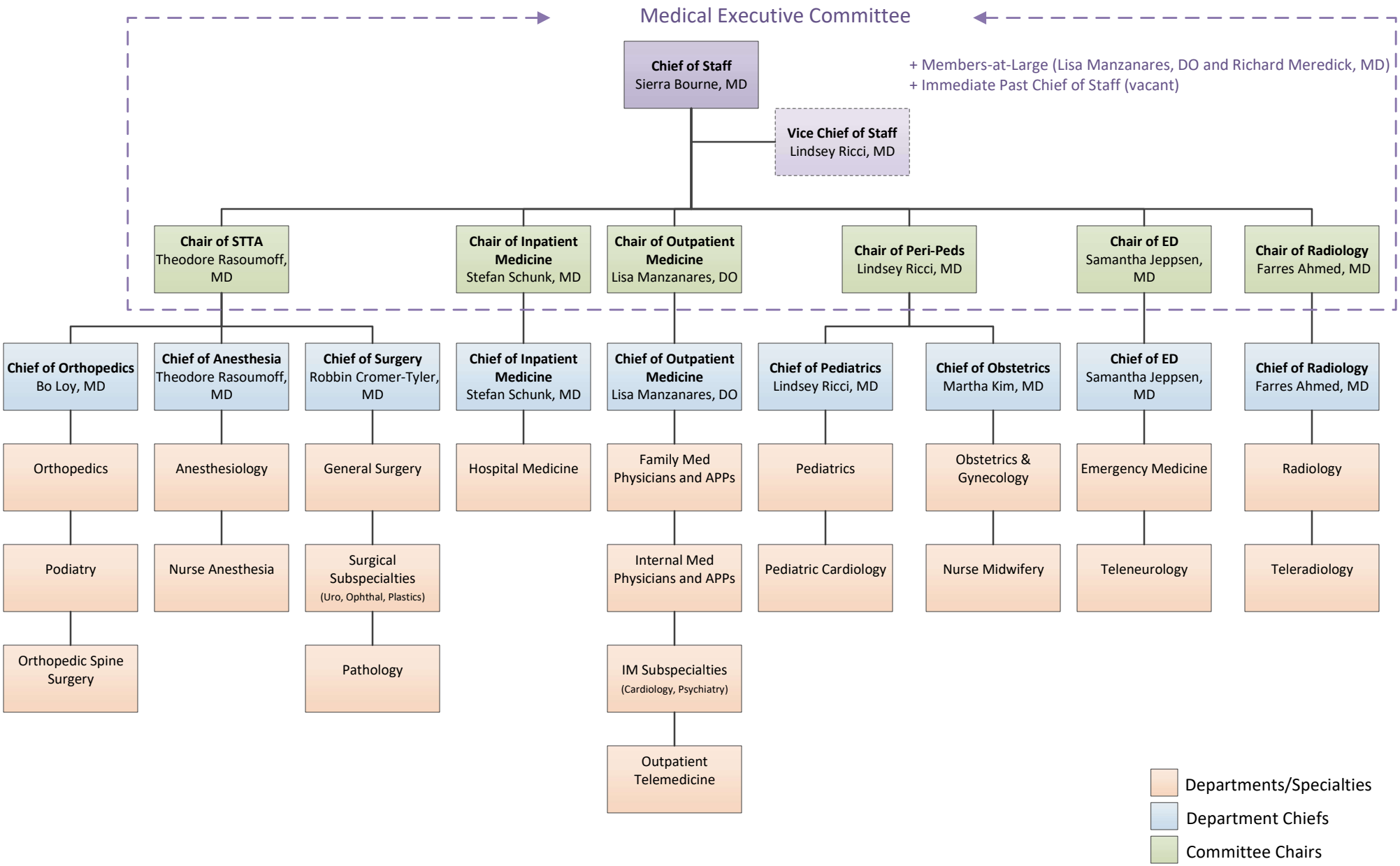
1. ACR Manual on MRI Safety (2020 edition)
2. Dr. Kanal, Emmanual "Kanal's MRMD/MRSO MR Safety Training Course – Orlando, FL". Nov 3, 2019 – Nov 6, 2019. North West Imaging Forums, INC.
3. Kanal E, Barkovich AJ, Bell C, et al. ACR guidance document on MR safe practices: 2007. AJR AM J Roentgenol 2007;188:1447-1474
4. Kanal E, Barkovich AJ, Bell C, et al. ACR guidance document on MR safe practices:2013. J Magn Reson Imaging 2013;37;501-530.
5. U.S. Department of Health and Human Services Food and Drug Administration,
6. Center for Devices and Radiological Health. Criteria for significant risk investigations of magnetic resonance diagnostic devices. Guidance for industry and Food and Drug Administration staff.
7. International Commission on Non-Ionizing Radiation Protection. Guidelines on limits of exposure to static magnetic fields. Health Phys 2009;96:504–514.
8. The Joint Commission: Diagnostic imaging requirements, issued August 10, 2015. Available at https://www.jointcommission.org/diagnostic_imaging_standards/.
9. The ACR Guidance Statement on MR Safe Practice, issued 2013, 2018, 2019 https://www.acr.org/Clinical-Resources/Radiology-Safety/MR-Safety

CROSS REFERENCED POLICIES AND PROCEDURES:

- DI - MRI Safety - Burn/Thermal Incident Reduction Policy
- DI - MRI Safety – Special Patient Population Management
- DI – MRI Safety – Noise Protection
- DI – MRI Safety – Patient and Caretaker Screening
- DI – MRI Safety – MRI Access Control – NIHD Staff
- DI – MRI Safety – MRI Safety Organizational Structure
- DI – MRI Safety – NIHD Specific Zone Identification
- Cylinder Safe Handling

Supersedes: Not Set

Medical Staff Governance Structure
July 1, 2024 – June 30, 2025
Rev. 06/21/24



Note: A Chair and Chief may be the same individual. Chairs and Chiefs are elected positions.

CALL TO ORDER

The meeting was called to order at 5:30 p.m. by Melissa Best-Baker, Northern Inyo Healthcare District (NIHD) Board Chair.

PRESENT

Melissa Best-Baker, Chair
Jean Turner, Vice Chair
Ted Gardner, Secretary
David McCoy Barrett, Treasurer
Mary Mae Kilpatrick, Member-at-Large
Stephen DelRossi, MSA, Chief Executive Officer

ABSENT

Allison Partridge RN, MSN, Chief Operations Officer / Chief Nursing Officer
Adam Hawkins, DO, Chief Medical Officer
Alison Murray, Chief Human Resources Officer
Sierra Bourne, MD, Chief of Staff

CLOSED SESSION:

OPPORTUNITY FOR PUBLIC COMMENT

Chair Best-Baker reported that at this time, members of the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the Notice for this meeting.

There were no comments from the public.

ADJOURNMENT TO CLOSED SESSION:

At 5:32 p.m., Chair Best-Baker announced the meeting would adjourn to Closed Session to allow the District Board of Directors to discuss the following:

a. Public Employee Performance Evaluation (pursuant to Government Code Section 54957 (e)) title: Chief Executive Officer

At 8:17 p.m., Chair Best-Baker announced that there would be no report out.

ADJOURNMENT

Adjournment at 8:18 p.m.

_____
Jean Turner, Northern Inyo Healthcare District, Vice Chair

Attest: _____

Ted Gardner, Northern Inyo Healthcare District, Secretary

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Jean Turner, Northern Inyo Healthcare District, Vice Chair

Attest: _____

Ted Gardner, Northern Inyo Healthcare District, Secretary

July 2024 Statement

Open Date: 06/06/2024 Closing Date: 07/05/2024

Account: [redacted]

[redacted]

U.S. Bank Business Platinum Card
NORTHERN INYO HOSPITA
STEPHEN DELROSSI ([redacted])

Cardmember Service [redacted]

New Balance	**$5,173.77**
Minimum Payment Due	**$52.00**
Payment Due Date	**08/01/2024**

Activity Summary

Previous Balance	+	$2,112.83
Payments	-	$2,112.83CR
Other Credits	-	$200.00CR
Purchases	+	$5,373.77
Balance Transfers		$0.00
Advances		$0.00
Other Debits		$0.00
Fees Charged		$0.00
Interest Charged		$0.00
New Balance	**=**	**$5,173.77**
Past Due		**$0.00**
Minimum Payment Due		**$52.00**
Credit Line		$37,500.00
Available Credit		$32,326.23
Days in Billing Period		30

Payment Options:

Mail payment coupon with a check

Pay online at usbank.com

[redacted]

Pay at your local U.S. Bank branch

Please detach and send coupon with check payable to: U.S. Bank [redacted]

[redacted]

Account Number	[redacted]
Payment Due Date	8/01/2024
New Balance	$5,173.77
Minimum Payment Due	$52.00

24-Hour Cardmember Service: [redacted]

. to pay by phone
. to change your address

[redacted]

Amount Enclosed $_____

NORTHERN INYO HOSPITA
STEPHEN DELROSSI
150 PIONEER LN
BISHOP CA 93514-2556
[redacted]

U.S. Bank
[redacted]

What To Do If You Think You Find A Mistake On Your Statement
If you think there is an error on your statement, please call us at the telephone number on the front of this statement, or write to us at:
[redacted]
In your letter or call, give us the following information:
▶ *Account information:* Your name and account number.
▶ *Dollar amount:* The dollar amount of the suspected error.
▶ *Description of Problem:* If you think there is an error on your bill, describe what you believe is wrong and why you believe it is a mistake.
You must contact us within 60 days after the error appeared on your statement. While we investigate whether or not there has been an error, the following are true:
▶ We cannot try to collect the amount in question, or report you as delinquent on that amount.
▶ The charge in question may remain on your statement, and we may continue to charge you interest on that amount. But, if we determine that we made a mistake, you will not have to pay the amount in question or any interest or other fees related to that amount.
▶ While you do not have to pay the amount in question, you are responsible for the remainder of your balance.
▶ We can apply any unpaid amount against your credit limit.
Your Rights If You Are Dissatisfied With Your Credit Card Purchases
If you are dissatisfied with the goods or services that you have purchased with your credit card, and you have tried in good faith to correct the problem with the merchant, you may have the right not to pay the remaining amount due on the purchase.
To use this right, all of the following must be true:
1. The purchase must have been made in your home state or within 100 miles of your current mailing address, and the purchase price must have been more than $50. (Note: Neither of these are necessary if your purchase was based on an advertisement we mailed to you, or if we own the company that sold you the goods or services.)
2. You must have used your credit card for the purchase. Purchases made with cash advances from an ATM or with a check that accesses your credit card account do not qualify.
3. You must not yet have fully paid for the purchase.
If all of the criteria above are met and you are still dissatisfied with the purchase, contact us in writing at: Cardmember Service, [redacted]
While we investigate, the same rules apply to the disputed amount as discussed above. After we finish our investigation, we will tell you our decision. At that point, if we think you owe an amount and you do not pay we may report you as delinquent.
Important Information Regarding Your Account
1. **INTEREST CHARGE:** Method of Computing Balance Subject to Interest Rate: We calculate the periodic rate or interest portion of the **INTEREST CHARGE** by multiplying the applicable Daily Periodic Rate (**"DPR"**) by the Average Daily Balance (**"ADB"**) (including new transactions) of the Purchase, Advance and Balance Transfer categories subject to interest, and then adding together the resulting interest from each category. We determine the **ADB** separately for the Purchases, Advances and Balance Transfer categories. To get the **ADB** in each category, we add together the daily balances in those categories for the billing cycle and divide the result by the number of days in the billing cycle. We determine the daily balances each day by taking the beginning balance of those Account categories (including any billed but unpaid interest, fees, credit insurance and other charges), adding any new interest, fees, and charges, and subtracting any payments or credits applied against your Account balances that day. We add a Purchase, Advance or Balance Transfer to the appropriate balances for those categories on the later of the transaction date or the first day of the statement period. Billed but unpaid interest on Purchases, Advances and Balance Transfers is added to the appropriate balances for those categories each month on the statement date. Billed but unpaid Advance Transaction Fees are added to the Advance balance of your Account on the date they are charged to your Account. Any billed but unpaid fees on Purchases, credit insurance charges, and other charges are added to the Purchase balance of the Account on the date they are charged to the Account. Billed but unpaid fees on Balance Transfers are added to the Balance Transfer balance of the Account on the date they are charged to the Account. In other words, billed and unpaid interest, fees, and charges will be included in the **ADB** of your Account that accrues interest and will reduce the amount of credit available to you.To the extent credit insurance charges, overlimit fees, Annual Fees, and/or Travel Membership Fees may be applied to your Account, such charges and/or fees are not included in the ADB calculation for Purchases until the first day of the billing cycle following the date the credit insurance charges, overlimit fees, Annual Fees and/or Travel Membership Fees (as applicable) are charged to the Account. Prior statement balances subject to an interest-free period that have been paid on or before the payment due date in the current billing cycle are not included in the **ADB** calculation.
2. **Payment Information:** We will accept payment via check, money order, the internet (including mobile and online) or phone or previously established automatic payment transaction. You must pay us in U.S. Dollars. If you make a payment from a foreign financial institution, you will be charged and agree to pay any collection fees added in connection with that transaction. The date you mail a payment is different than the date we receive the payment. The payment date is the day we receive your check or money order at U.S. Bank National Association, [redacted] or the day we receive your internet or phone payment. All payments by check or money order accompanied by a payment coupon and received at this payment address will be credited to your Account on the day of receipt if received by 5:00 p.m. CT on any banking day. Payments sent without the payment coupon or to an incorrect address will be processed and credited to your Account within 5 banking days of receipt. Payments sent without a payment coupon or to an incorrect address may result in a delayed credit to your Account, additional interest charges, fees, and/or Account suspension. The deadline for on-time internet and phone payments varies, but generally must be made before 5:00 p.m. CT to 8 p.m. CT depending on what day and how the payment is made. Please contact Cardmember Service for internet, phone, and mobile crediting times specific to your Account and your payment option. Banking days are all calendar days except Saturday, Sunday and federal holidays. Payments due on a Saturday, Sunday or federal holiday and received on those days will be credited on the day of receipt. There is no prepayment penalty if you pay your balance at any time prior to your payment due date.
3. **Credit Reporting:** We may report information on your Account to Credit Bureaus. Late payments, missed payments or other defaults on your Account may be reflected in your credit report.

NORTHERN INYO HOSPITA
STEPHEN DELROSSI ([redacted])

Cardmember Service ([redacted])

Important Messages

Paying Interest: You have a 24 to 30 day interest-free period for Purchases provided you have paid your previous balance in full by the Payment Due Date shown on your monthly Account statement. In order to avoid additional INTEREST CHARGES on Purchases, you must pay your new balance in full by the Payment Due Date shown on the front of your monthly Account statement.

There is no interest-free period for transactions that post to the Account as Advances or Balance Transfers except as provided in any Offer Materials. Those transactions are subject to interest from the date they post to the Account until the date they are paid in full.

Skip the mailbox. Switch to e-statements and securely access your statements online. Get started at usbank.com/login.

Transactions

Payments and Other Credits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
06/24	06/21	[redacted]	ACHD* CA WWW.ACHD.ORG CA MERCHANDISE/SERVICE RETURN	$200.00CR	
06/26	06/26	[redacted]	INTERNET PAYMENT THANK YOU	$2,112.83CR	
			TOTAL THIS PERIOD	**$2,312.83CR**	

Purchases and Other Debits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
06/21	06/20	[redacted]	THE UPPER CRUST PIZZA [redacted] — Lab Team lunch	$112.93	
06/21	06/20	[redacted]	AMAZON [redacted] — Bulletin Board	$33.68	
06/24	06/21	[redacted]	ACHD* CA [redacted] — AHCD CEO Registration	$925.00	
06/26	06/24	[redacted]	UNITED [redacted]	$85.99	
06/26	06/24	[redacted]	UNITED [redacted] — CEO travel for Becker's Conference (4 total)	$79.99	
06/26	06/24	[redacted]	UNITED [redacted]	$79.99	
06/26	06/24	[redacted]	UNITED [redacted]	$85.99	
07/01	06/27	[redacted]	MBAY FRONT DESK [redacted] — CEO Hotel for Becker's Conference	$1,024.25	
07/01	06/30	[redacted]	FACEBK [redacted] — Marketing	$377.17	
07/02	07/01	[redacted]	ACHD* [redacted] — Board ACHD Registration	$2,400.00	
07/03	07/02	[redacted]	ACHD* [redacted] — ACHD CEO Governance Day registration	$75.00	
07/03	07/02	[redacted]	OPTIMUM [redacted] — Cable/Internet	$93.78	
			TOTAL THIS PERIOD	**$5,373.77**	

2024 Totals Year-to-Date

Total Fees Charged in 2024	$78.00
Total Interest Charged in 2024	$255.74

Company Approval *(This area for use by your company)*

Signature/Approval: _____ Accounting Code: _____

Continued on Next Page

NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

Cardmember Service [redacted]

Interest Charge Calculation

Your Annual Percentage Rate (APR) is the annual interest rate on your account.

****APR for current and future transactions.

Balance Type	Balance By Type	Balance Subject to Interest Rate	Variable	Interest Charge	Annual Percentage Rate	Expires with Statement
**BALANCE TRANSFER	$0.00	$0.00	YES	$0.00	24.24%	
**PURCHASES	$5,173.77	$0.00	YES	$0.00	24.24%	
**ADVANCES	$0.00	$0.00	YES	$0.00	29.99%	

Contact Us

Phone [redacted]

Questions [redacted]

Mail payment coupon with a check [redacted]

Online [redacted]

End of Statement

NORTHERN INYO HOSPITA

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: Laboratory Biosafety Plan		
Owner: Medical Laboratory Services Manager	Department: Laboratory	
Scope: Laboratory Services		
Date Last Modified: 07/03/2024	Last Review Date: 07/03/2024	Version: 1
Final Approval by: Medical Director of Laboratory & Medical Executive Committee	Original Approval Date: 07/02/2024	

PURPOSE:

The goal of this plan is to minimize or eliminate health care worker exposure to potential laboratory associated infections (LAI). This plan focuses on safe work practices, personal protective equipment, and engineering and administrative controls. Adhering to this plan ensures compliance with all applicable laws and regulations relating to safe practices for biosafety levels, and is in accordance with Title 8, California Code of Regulations, Section 5199. This plan continues our commitment to providing a safe and healthy environment in which to deliver patient care.

POLICY:

Northern Inyo Healthcare District (NIHD) is committed to providing a safe and healthy environment for its entire staff. All employees working within this facility who may be potentially exposed to pathogens within the clinical laboratory, including the microbiology laboratory, will follow this policy. Failure to follow this policy may result in disciplinary actions.

Specimens from patients with suspected or confirmed Ebola or Viral Hemorrhagic Fever will not be accepted in the laboratory, as NIHD does not have proper engineering controls for safe handling or testing.

NIHD will always follow federal, state, and local guidelines/recommendations pertaining to emerging pathogens.

Note: Safety in the laboratory is the responsibility of all personnel. All personnel must have orientation and hands on training followed by an initial Competency Assessment (CA). The initial CA is followed by a 12-month and then annual CA. Testing personnel is required to be knowledgeable of the information in this policy.

DEFINITIONS:

Biosafety cabinet (BSC) - Principal safety equipment used to provide containment of infectious droplets or aerosols generated by many microbiological procedures. There are three classes of BSCs (Class I, II, III) used in microbiological laboratories. Open-fronted Class I and Class II BSCs are primary barriers that offer significant levels of protection to laboratory personnel and to the environment when used with good microbiological techniques. The Class II biological safety cabinet also provides protection from external contamination of the materials (e.g. cell cultures, microbiological stocks) being manipulated inside the cabinet. The gas-tight Class III biological safety cabinet provides the highest attainable level of protection to personnel and the environment.

Biosafety levels (BSL) - Combinations of laboratory practices and techniques, safety equipment, and laboratory facilities. Each combination is specifically appropriate for the operations performed, the documented or suspected routes of transmission of the infectious agents, and the laboratory function or activity.

BSL-2 designation - Suitable for work with agents associated with human disease and pose moderate hazards to personnel and the environment. BSL-2 differs from BSL-1 primarily because: 1) laboratory personnel receive **specific training** in handling pathogenic agents and are supervised by scientists competent in handling infectious agents and associated procedures; 2) **access to the laboratory is restricted** when work is being conducted; and 3) **all procedures** in which infectious aerosols or splashes may be created are **conducted in BSCs** or other physical containment equipment.

BSL-3 designation - Suitable for work with indigenous or exotic agents that may cause serious or potentially lethal disease through the inhalation route of exposure. Laboratory personnel receive specific training in handling pathogenic and potentially lethal agents, and they are supervised by scientists competent in handling infectious agents and associated procedures. A BSL-3 laboratory has **special engineering and design features**.

Contaminated – The presence or the reasonably anticipated presence of potentially infectious materials on a surface or in or on an item.

Decontamination – The use of physical or chemical means to remove, inactivate or destroy pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use or disposal.

Engineering controls – Controls such as BSC and sharps disposal containers that isolate a pathogen or remove the hazard from the workplace.

Exposure incident – Any eye, mouth, mucous membrane, non-intact skin, or other parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Occupational exposure – A job category where skin, eye, mucous membrane, or parenteral contact with potentially infectious materials could be reasonably anticipated.

Potentially infectious materials (PIM)

- Human body fluids: blood, semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, wound exudates, any other body fluid that is visibly contaminated with blood such as saliva or vomitus, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids such as in an emergency response
- Any unfixed tissue or organ ~~(other than intact skin)~~ from a human (living or dead)
- Any of the following, if known or reasonably likely to contain or be infected with Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV) or Hepatitis C Virus (HCV):
  - –Cell, tissue, or organ cultures from humans or experimental animals
  - –Blood, organs or other tissues from experimental animals
  - –Culture medium or other solutions

Standard precautions – An approach to infection control. Standard precautions expand the universal precautions concept (see below) to include all other potentially infectious materials with the intent of protecting employees from any disease process that can be spread by contact with a moist body substance. This isolation technique includes substances such as feces, urine, saliva and sputum that were not included in universal precautions unless they contain visible blood.

Universal precautions – Is an approach to infection control to treat all human blood and certain human body fluids as if they were known to be infectious for HIV, HBV and other blood borne pathogens. Universal Precautions emphasizes the use of Personal Protective Equipment (PPE) to prevent contact with blood and other

potentially infectious materials. Precautions apply to blood, semen, vaginal secretions, amniotic, cerebrospinal, pericardial, peritoneal, pleural, synovial fluids and any other body fluid visibly contaminated with blood.

METHODS OF COMPLIANCE

This section reviews the numerous work practices and procedures necessary to minimize or eliminate un-protected exposure to PIM. Compliance with these practices and procedures is **MANDATORY** for laboratory personnel and is a condition of employment.

Biosafety Level 2 (Microbiology)

Biosafety Level 2 practices, equipment, and facility design and construction are applicable to clinical laboratories in which work is done with the broad spectrum of indigenous moderate-risk agents that are present in the community and associated with human disease of varying severity. With good microbiological techniques, these agents can be used safely in activities conducted on the open bench, provided the potential for producing splashes or aerosols is low. Hepatitis B virus, HIV, *Salmonella*, and *Toxoplasma* are representative of microorganisms assigned to this containment level. BSL-2 is appropriate when work is done with any human-derived blood, body fluids and tissues where the presence of an infectious agent may be unknown. (Laboratory personnel working with human-derived materials should refer to the OSHA Blood borne Pathogen Standard [2] for specific required precautions).

Primary hazards to personnel working with these agents relate to accidental percutaneous or mucous membrane exposures or ingestion of infectious materials. Extreme caution should be taken with contaminated needles or sharp instruments. Even though organisms routinely manipulated at BSL-2 are not known to be transmissible by the aerosol route, **procedures with aerosol or high splash potential that may increase the risk of such personnel exposure must be conducted in primary containment equipment, or in devices such as a BSC**. Therefore, all biological specimens received in the Microbiology Section have to be processed in a BSC II. Personal protective equipment are used as appropriate, such as splash shields, face protection, gowns, and gloves.

Secondary barriers, such as hand washing sinks and waste decontamination facilities, must be available to reduce potential environmental contamination.

Standard Precautions

Refer to Lippincott Procedures Standard Precautions.

Use standard precautions in all areas to prevent contact with PIM.

The Laboratory Director at NIHD is responsible for overseeing the use of standard precautions by all laboratory employees in this setting.

Engineering Controls:

The clinical laboratory uses engineering controls to minimize or eliminate occupational exposures to pathogens. These controls include, but are not limited to:

- Sharps with engineering controls, such as needleless systems
- Needle devices and non-needle sharps
- Handwashing facilities
- Leak proof specimen containers

- Laboratory safety hoods where appropriate

Work Practice Controls:

The use of standard precautions is an integral part of this biosafety plan. Standard precautions is practiced whenever exposure to PIM is anticipated.

Work practice controls/procedures is implemented to minimize exposure to PIM. Each department supervisor is responsible for implementing, evaluating and monitoring compliance with these work practices. The laboratory director and laboratory safety officer will monitor work practices as part of routine rounds through each area.

Specific infection control policies and procedures are in place to address work practices and procedures centered on the concept of standard precautions. The minimization and elimination of exposure to PIM is the primary goal.

The following is a summary of work practice controls:

- Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited at any time.
- Food, drink and oral medications will not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where PIM may be present.
- Laboratory coats are required
- Doors to the laboratory are closed when BSL-2 work is being conducted to prevent public access
- Biohazard signs must be posted
- Storage of biohazardous waste material in double red bags held in rigid, leak proof containers with biohazard labels on the top and side in all areas of the laboratory is required.
- All procedures involving PIM will be performed in such a manner as to minimize splashing, spraying, splattering and generation of droplets.
- Mucous membranes and eyes will be immediately flushed with water following exposure to blood or other PIM.
- Mouth pipetting/suctioning of blood or other PIM is prohibited.
- Handwashing with soap and water or alcohol based hand rub (ABHR) is required after working with PIM and before leaving the laboratory.
  Note: Hands must be washed with soap and water if there is any visible contamination with blood or other fluids.
- Decontamination is required after routine work, at the completion of a work shift, or in emergency situations, such as spill clean-up. Bench tops need to be cleaned at least daily (more frequently if needed). It is recommended to follow decontamination with 10% bleach with 70% ethanol to avoid corrosion.
- Centrifuge should only be used when the covers are closed. Minimize production of aerosols by centrifuging sealed tubes. Avoid centrifuging flammable liquids.
- Specimens of PIM will be placed in containers that prevent leakage during collection, handling, processing, storage, transportation or shipping. Syringes containing blood or other potentially infectious materials will not be transported with needles attached unless an engineered safety device is in place permanently shielding the needle.

- The container for storage, transport or shipping to outside of the facility will be labeled or color-coded with the legend **BIOHAZARD**. These labels shall be fluorescent orange or orange-red, with lettering and symbols in a contrasting color.
- If outside contamination of the primary container occurs, the primary container will be placed within a second container that prevents leakage during handling, processing, storage, transport or shipping and is properly labeled. If specimen could puncture the primary container, the primary container will be placed within the secondary container that is also puncture-resistant.

Communicating Hazards to Employees:

In addition to the provisions of standard precautions, the following hazard communication provisions are implemented as part of the exposure control plan:

- Biohazardous waste will be collected in red bags pre-printed with both the word **BIOHAZARD** and the biohazard symbol.
- Warning labels with the legend **BIOHAZARD** will be affixed to refrigerators and freezers containing potentially infectious materials and all other containers used to store, transport or ship potentially infectious materials.
- Biohazardous wastes will be labeled with the legend **BIOHAZARDOUS WASTE** or **SHARPS WASTE** as appropriate. Labels shall be fluorescent orange or orange-red, with lettering and symbols in a contrasting color.

The following items ***DO NOT*** require hazard labels/signs:

- Containers of blood or blood products already labeled as to their contents and released for transfusion or other clinical use.
- Individual containers, tubes and specimen cups of blood or other potentially infectious materials placed in biohazard labeled bags or containers for storage, transport, shipment or disposal.
- Primary specimen containers, as all staff are trained to use standard precautions when handling patient specimens.
- Laundry bags and containers, as both staff and laundry workers are trained in standard precautions.
- Biohazardous (regulated) waste which has been decontaminated (e.g., processed in a sterilizer) prior to disposal.

Note: The California Medical Waste Management Act also requires hazard-warning signs/labels of biohazardous waste. The requirements of this exposure plan are not intended to supersede these requirements but augment them.

Information and Training:

All employees covered by this plan will be provided training at the time of initial assignment to an at-risk job classification.

Training will be provided by the Laboratory Safety Officer or Clinical Microbiology Lead or assigned trainer whichever is applicable. Training will be provided in the language and vocabulary appropriate to the employee's education, literacy and language background.

Training will occur:

- At the time of initial assignment to an at-risk job classification.
- Annually, within 12 months of the previous training.

- When changes affect the employee's occupational exposure, such as new engineering, administrative or work practice controls, modifications of tasks/procedures or institution of new tasks/procedures. This training may be limited to these changes.

The training program will contain, at a minimum, the following elements:

- Copy and explanation of the Standard – A copy of Cal/OSHA's Blood borne Pathogens Standard is available for review in the Infection Prevention department and this plan.
- Epidemiology and symptoms – A general explanation of the epidemiology and symptoms of blood borne pathogens.
- Modes of transmission – A general explanation of the modes of transmission of blood borne pathogens.
- Employer's exposure control plan – An explanation of the plan and how an employee can obtain a copy.
- Risk identification – An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
- Methods of compliance – An explanation of the use and limitations of methods to prevent or reduce exposure, including appropriate engineering controls, administrative or work practice controls, and personal protective equipment.
- Personal protective equipment – Information on the types, proper use, location, removal and an explanation of the basis for selecting personal protective equipment.
- Decontamination and disposal – Information on handling and the decontamination and disposal of personal protective equipment.
- Vaccination program – Information on hepatitis B and meningococcal vaccine, including efficacy, safety, method of administration, the benefits of being vaccinated, and that it will be offered free of charge.
- Emergencies – Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
- Exposure incident – An explanation of the procedure to follow if an exposure incident occurs, including how the incident should be reported, the medical follow-up available and the procedure for recording the incident on the sharps injury log.
- Post-exposure evaluation and follow-up – Information on the post-exposure evaluation and follow-up that will be provided to the employee after an exposure incident.
- Signs and labels – An explanation of the signs, labels and/or color coding used to identify hazards.
- Interactive questions and answers – An opportunity for interactive questions and answers with the trainer.

Training Records

Full documentation of training must be completed for all employees trained. Documentation will be maintained by, and be the responsibility of, department managers and the Infection Preventionist. Documentation will be maintained for a minimum of three years from the date of training and then transferred to permanent storage.

Training records must include, at a minimum, the following:

- Date of training session
- Summary of content
- Names and job titles of attendees
- Names and qualifications of trainers

Handling Sharps

Reporting and Documenting Sharps Injuries: Refer to "Blood borne Pathogen Exposure Control Plan" and "Initial Evaluation of Exposure Incident policies/procedures".

All procedures involving the use of sharps in connection with patient care will be performed using all methods as described in the Bloodborne Pathogen Exposure Control Plan to minimize risk of a sharps injury.

Personal Protective Equipment:

- Personal protective equipment is an essential component of a plan to reduce or eliminate exposure to blood borne pathogens. PPE will be used in conjunction with engineered controls and work practice controls.
    - LINKS to Lippincott Procedures
        - Lippincott Standard Precautions. https://procedures.lww.com/lnp/view.do?pId=3260849&hits=standard&a=false&ad=false&q=standard
        - Personal Protective Equipment (PPE's) Putting On. https://procedures.lww.com/lnp/view.do?pId=3260961&hits=ppe&a=false&ad=false&q=PPE

    Personal Protective Equipment (PPE's) Removing with critical notes. https://procedures.lww.com/lnp/view.do?pId=3260962&hits=ppe&a=false&ad=false&q=PPE

Cleaning and Decontaminating the Work Site:

Listed below are cleaning and decontaminating policies and procedures that must be followed:

- Laboratory workspaces will be wiped down at least daily with cleaning and disinfectant such as disinfecting wipes, as determined by Infection Prevention.
- Environmental Services (EVS) is responsible for maintaining the facility in a clean and sanitary manner. Policies and procedures have been developed and implemented to ensure that cleaning is scheduled appropriately and proper methods for cleaning and decontaminating are followed. A written schedule for cleaning and decontaminating the worksite has been developed and is posted in EVS work stations and in the EVS manual.
- All dirty linen is handled in compliance with standard precautions. All appropriate steps are taken to minimize or eliminate potential exposures. If the soiled linen is wet and presents the likelihood of causing exposure, a plastic bag will be used to prevent leakage or exposure.
- Linen will be bagged or containerized at the point of use and will not be sorted or rinsed in this location.
- The Infection Control Committee is responsible for reviewing and approving policies and procedures that address proper cleaning, disinfection, and/or sterilization of equipment or environmental surfaces that become contaminated.

A summary of cleaning requirements follows:

- All equipment and environmental and work surfaces will be cleaned and decontaminated as soon as possible after contact with blood or other potentially infectious materials.
- Contaminated work surfaces, or surfaces that come into contact with the hands, will be cleaned and decontaminated immediately or as soon as feasible in the event they become overtly contaminated, when blood or other potentially infectious materials fluid spills occur, or when procedures are completed, using a hospital-approved cleaning and disinfectant product.

- All bins, pails, cans and similar receptacles that become contaminated with blood or other potentially infectious materials will be cleaned and decontaminated immediately or as soon as feasible, no later than at the end of the work shift.
- Protective coverings such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment or environmental surfaces will be removed, replaced and appropriately disposed of at the end of each work shift. If such covering becomes overtly contaminated, it will be removed and disposed of immediately or as soon as feasible.

Waste Disposal

The California Medical Waste Management Act, in conjunction with this plan, will provide direction on the proper disposal of biohazardous waste to include sharps waste and wastes contaminated with blood or other PIM. The following will be placed in red plastic bags marked with the word and symbol for **BIOHAZARD** and disposed of using the biohazard waste pathway:

- Liquid or semi-liquid blood or other potentially infectious materials
- Contaminated items that contain liquid or semi-liquid blood or are caked with dried blood and are capable of releasing these materials when handled or compressed
- Contaminated sharps
- Pathological and microbiological wastes containing blood or other potentially infectious materials

Vaccination Programs:

In an effort to provide maximum protection from hepatitis B and meningococcal infection, NIHD offers a vaccination program, at no cost for employees, to all staff that has potential occupational exposure to blood borne pathogens, including laboratory personnel.

Refer to Employee Health NIHD Workforce Onboarding

- Laboratory employees will be offered the HBV vaccine free of charge from Employee Health.
- Clinical Laboratory Scientists (CLS) working in Microbiology will be offered a meningococcal vaccine free of charge from Employee Health.

Post-Exposure Evaluation and Follow-Up:

A blood borne pathogen exposure prophylaxis protocol has been implemented to provide an immediate, confidential medical evaluation and follow-up of employees exposed to blood or other potentially infectious materials. This protocol is in accordance with the most recent recommendations of the U.S. Public Health Services.

Exposure Evaluation* link to P&P *Note: The Standard requires providers to follow procedures as recommended by the U.S. Public Health Services. The Centers for Disease Control and Prevention (CDC) periodically issue new recommendations. Providers, and in particular, medical professionals who conduct post-exposure evaluations, need to keep updated on the CDC's recommendations.*

Current recommendations and checklists are incorporated into packets and outlined below to ensure comprehensive and appropriate treatment.

- The protocol and information packets are available from the infection policies and procedures manual. Detailed instructions and all necessary forms are included in the packet for the employee, supervisor and physician, to ensure the evaluation is comprehensive and thorough.

- Medical evaluation, counseling and follow-up will be conducted by the Nursing Supervisor, Emergency Department, Infection Preventionist, and Employee Health.
- All medical records will be maintained in the patient's confidential employee health file.
- The Infection Preventionist, Employee Health, or designee will advise the employee-patient of the right to refuse consent of post-exposure evaluation and follow-up from his/her health care employer. If consent is refused, a confidential medical evaluation and follow-up will be made immediately available by an outside health care professional. Medical evaluation and laboratory tests will be provided at no cost to the employee.

Recordkeeping:

Records covered in this section are available through Human Resources, Employee Health, and Infection Prevention. Records must be made available under these circumstances:

- All records (training records, medical records and sharps injury log) will be provided upon request to Cal/OSHA and NIOSH for examination and copying.
- Employee training records will be provided upon request to employees and employee representatives.
- Employee medical records will be provided to the subject employee upon request for examination and photocopying. Anyone with written consent from this employee may also request the medical records.
- The sharps injury log is available upon request to examine and photocopy, and will be made available to employees and to employee representatives upon request.
- The sharps injury log will be maintained in by Employee Health for a minimum of five years.

Medical Records

A medical record for each employee who performs duties that may result in an exposure incident will be maintained by Employee Health. These records will include the following information:

- The name and social security number of the affected employee.
- A copy of the employee's vaccination status including the dates of all vaccinations and any medical records relative to the employee's ability to receive vaccination.
- A copy of all examination and medical testing results, and follow-up procedures.
- The employer's copy of the health care professional's written opinion.
- A copy of the information provided to the health care professional.

  Note: These records will be kept confidential and will not be disclosed or reported without the employee's expressed written consent except as required by Title 8, California Code of Regulations, Section 3204, and other applicable laws. These records will be maintained within the above listed departments for at least the duration of employment plus 30 years.

Annual Review

A review of pathogens that potentially lead to laboratory-associated infections (LAI) will be conducted each year. This review falls into the responsibility of the Clinical Microbiology Lead. The Microbiology Lead is responsible for reviewing and updating the biosafety plan annually or more frequently if necessary to reflect any new or modified tasks and procedures that affect occupational exposure. See attachment for organism list, LD Form 492.

REFERENCES:

1. Biosafety in Microbiological and Biomedical Laboratories, 6th Edition, U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention (CDC), National Institutes of Health, Revised June 2020
2. The Joint Commission (2018). Infection Prevention and Control IC.02.03.01. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx
3. State of California: Department of Industrial Relations (Last accessed 2/20/2017). Exposure control plan for Blood borne Pathogens. Retrieved from https://www.dir.ca.gov/dosh/dosh_publications/expplan2.pdf
4. United States Department of Labor: Occupational Safety and Health Administration (OSHA) (Last accessed 2/20/2017). Blood borne Pathogens and Needle stick Prevention. Retrieved from https://www.osha.gov/SLTC/bloodbornepathogens/evaluation.html

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program
2. Injury and Illness Prevention Program
3. Employee Health NIHD Workforce Onboarding
4. Infectious/Non-Infectious Waste Disposal Procedure
5. Bloodborne Pathogen Exposure Control Plan
6. Transport of Laboratory Specimens using the Pneumatic Tube System
7. Hazardous Materials & Waste Management Plan
8. Exposure Evaluation*
9. Lippincott Standard Precautions. https://procedures.lww.com/lnp/view.do?pId=3260849&hits=standard&a=false&ad=false&q=standard
10. Personal Protective Equipment (PPE's) Putting On. https://procedures.lww.com/lnp/view.do?pId=3260961&hits=ppe&a=false&ad=false&q=PPE
11. Personal Protective Equipment (PPE's) Removing with critical notes. https://procedures.lww.com/lnp/view.do?pId=3260962&hits=ppe&a=false&ad=false&q=PPE

RECORD RETENTION AND DESTRUCTION:

Laboratory, Employee Health and Infection Prevention record retention policies will be followed.

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Environmental Tours EC.04.01.01EP12-14		
Owner: Director of Facilities	Department: Plant Services	
Scope: Northern Inyo Healthcare District		
Date Last Modified: 06/25/2024	Last Review Date:	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/16/2015	

PURPOSE:
The purpose of this policy is to implement processes for conducting regular environmental tours.

POLICY

It is the policy of Northern Inyo Healthcare District (NIHD) to conduct regular environmental tours of all areas of the organization to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks.

PROCEDURE

1. As part of an ongoing environment of care program, the Safety Officer shall coordinate the environmental tours of the facility, to identify and evaluate information concerning safety, fire safety, hazardous conditions, exposure to hazardous materials and wastes, security, utilities, medical equipment and staff knowledge.

2. An Environmental Tour Team will be utilized (when possibly) in conducting the tours and documentation of the inspections.
   a. The team members will perform the tours as scheduled by the Safety Officer
   b. The Team will consist of representatives from at least the following departments:

      i. Security
      ii. Infection Control
      iii. Environmental Services
      iv. Engineering/Maintenance

3. Environmental tours will be conducted in all patient care areas <u>every six months</u>.

4. Environmental tours will be conducted in all non-patient care areas <u>annually</u>.

5. Inspections will be performed and documented by area, clinical or non-clinical, utilizing the Environmental Tour Inspection Form (*Attachment I and II*). Each of the questions has been given a rating to determine the amount of time that the item should be addressed, if there is an issue. The rating system is as follows:

a. Rating 1- should be addressed immediately before the conductor of the inspection leaves the area.
b. Rating 2- should be addressed within 24-48 hours of the inspection.
c. Rating 3- should be addressed within 15 days of the inspection.
d. Rating 4- should be addressed within 30 days of the inspection.

6. All identified discrepancies and issues will be documented on the form and submitted to the Safety Officer after completion. During the tour, if the charge nurse, department manager, or director is available, indicate the issues and show them where they are located.

7. The Safety Officer will document the inspection for completion and the identified deficiencies or issues will addressed, dependent on the issue and responsibility, by the following individuals:

   a. Affected Department Director/Managers
   b. Maintenance Department
   c. Clinical Engineering Department
   d. Environmental Services

8. The Safety Officer will document the deficiencies and issues by the rating and document the corrective actions to the issues completed during the inspection.

9. The Safety Officer will send an Environmental Tour Memorandum (*Attachment III*) and a copy of the inspection to the appropriate director or manager of the department inspected. This is only done if there are problems noted.

10. The Department Director/Manager will review the information sent and work on the issues and deficiencies that have been identified for the department to correct as soon as possible. Once the corrections have been completed for the issues identified, the information will be sent back to the Safety Officer.

11. The Safety Officer will continue to maintain the documentation of the environmental tours where issues identified. The issues will be addressed by the support services department through the work order system or by notifying the department of completion.

12. The Safety Officer will schedule, track, trend and analyze the environmental tour inspections (*Attachment IV*) and provide completion, data, and issues to the Environment of Care Committee on a monthly basis.

REFERENCES:

1. The Joint Commission CAMCAH Manual (Jan.-2021) EC.04.01.01 EP12-14